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Nursing News

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

July 2013 | *Official Newsletter of New Hampshire Nurses Association* | Vol. 37 No. 3

In My Opinion

96% of Nurses Reading This are Not NHNA Members

80% Do Not Belong to Any Professional Nursing Organization Why Is That Dangerous?

Judith Joy, RN, PhD
NHNA President

As I prepare to represent you at the first ever American Nurses Association (ANA) Membership Assembly it occurs that both ANA and NHNA are responding to a new world view. Membership organizations, nursing included, have been impacted by the worldwide financial crises. Not only is everything that we purchase in service to our members more expensive but the products we offer must often be more expensive. Some members have decided that dues money might be useful elsewhere. Other groups, national unions predominantly, have lured nurses away with promises of financial and job security. In response, both the ANA and NHNA have been working non-stop to make our organizations more effective and efficient to meet the needs of nurses today.

So what are the needs of nurses today? I would suggest that some things have not changed much over the years, some have changed dramatically.

Over the past years of my career, nurses across the country have fought to be recognized financially as well as professionally. Clearly nurses of today need to be paid a fair wage for the important, often stressful, always very demanding work we do. Although being acknowledged as a professional has been, from the beginning, a significant but perhaps 'ivory tower' need of practicing nurses, the question becomes: *Does being a professional mean anything to the day-to-day practice of nurses? Does it*

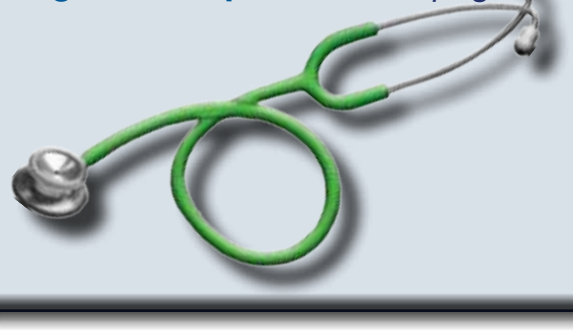
President's Message continued on page 2

BIG NEWS ON ITS WAY!

ANA has performed extensive member research over the last year.
We heard what you had to say and plan on making some big changes.

ANA and the NH Nurses' Association are working together to bring you very exciting membership news soon. Check our website after August 1st for important details! www.NHNurses.org

Inside...



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impact the power we have to control working conditions, job satisfaction, or even pay? Let me explain why I think it does.

We (your Nurses' Association) were recently invited to attend a strategy meeting called by a large citizens group addressing a major health care issue. It is important to note that we were invited – the organizers felt we were important partners in the effort they were making. During the course of that meeting it became obvious why we had been asked. Research they presented focused on not only how a health care message is presented to the public but by whom. Nurses, according to research, are 'trusted messengers.' The public has faith that the concerns and issues brought forth by nurses are credible; that nurses behave as true professionals in the best interest of their clients.

How does the public know that we can be trusted? In the same way you know friends, family or others can (or cannot) be trusted. We behave in a manner consistent with our stated values. We have values! We govern ourselves, defining standards of practice and then ensuring that nurses meet those standards. For those reasons we can and have reached out to the 'public' to support us; to be behind our efforts to increase our pay, to increase our scope of practice. We have enjoyed the trust and support of the public for many years. So why should that change?

The first and most obvious – nurses are the single largest profession in the United States, three million of us, about 1% of the entire population. Since salary is the largest recurring part of any budget, nursing is the single largest cost in health care. When finance gurus look around for a place to cut costs it does not take a wizard to determine where they might cast their glance. Do we have evidence this is occurring? Yes, indeed we do. According to the US Department of Labor medical assistants (MAs) are the fastest growing health care 'professional.' MAs are unregulated in NH and although many of them are well educated and may be certified by a credentialing body, many others are neither educated for the role nor credentialed. Thus they are not as well paid as nurses.

In another example, the American Medical Association has made it an organizational objective for physicians to legally control nurse practitioners. NH has, at this time, among the most progressive scope of practice descriptions for nurse practitioners. Even though the physician groups in NH do not appear to be interested in pursuing physician oversight, the national organization has made its position clear. There is much evidence the AMA is actively working with federal legislators to constrain advanced nurse practice from that level. As I have said in the past, this is not a competition with other clinicians. But it is naïve to believe that other clinicians are not advocating for themselves in a way that will impact our practice.

A local example: In the past several years the NH Legislature has required the NH Board of Nursing, the state organization whose role it is to regulate the practice of nursing, to cut its budget several times. Well, you might say, that's fair, money's short and belt tightening by everyone is the way it should be. That might be true if the Board of Nursing was funded by the State. Not so – it is funded by YOU! By state law the Board must be funded at 125% of its budget by the licensing and other fees it collects. Although it is tempting to believe that Board reductions won't impact nursing at the practice level, how can it not? Remember that our public supports us, trusts us, backs our statements when we say we need to have more nurses to increase quality and save money (not fewer), that we deserve to be paid well for the services we provide. If the Board is no longer able to uphold the practice standards set by the ANA, NHNA and other specialty nursing organizations how long will it be before that trust is eroded? Before the public believes that we have become self-serving, overpaid employees not the 'trusted messenger' reputation we enjoy now.

The NHNA has been monitoring and acting on your behalf in all of these situations. We do so as a volunteer organization funded predominantly by membership. Are we working as hard as we can to protect quality nursing practice, yes we are. Are we able to work as hard as we should? Since 96% of you do not support the organization that 'has your back' what do you think? And consider - who will advocate for us if we are not willing to do so for ourselves? **Now is the time to join!**

NURSING NEWS

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VISION STATEMENT

Cultivate the transformative power of nursing.
Adopted 10-20-2010.

MISSION STATEMENT

NHNA, as a constituent member of the American Nurses Association, exists to promote the practice, development and well being of NH nurses through education, empowerment and healthcare advocacy.
Adopted 10-20-2010.

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Health Policy Days - 2013

This years' sessions were held on March 21st and April 2nd in Concord for 160 participants, primarily graduating nursing students, from around the state. This annual event is adeptly coordinated by volunteers of our Government Affairs Commission (GAC).

GAC Co-Chair, Ginny Blackmer, APRN, began each day with an overview of the legislative structure and process in New Hampshire. Next, RN legislators take time between hearings to visit and share their experiences – emphasizing how nurses can positively impact healthcare related legislation, and discussing some of the current bills being followed. This year, State Senator Peggy Gilmour and State Representative Laurie Harding were able to present their motivating stories to each group.

NHNA's lobbyist Bob Dunn of Devine, Millimet and Branch; GAC Chair, Lisah Carpenter; NHNA President Judith Joy, President Elect Barbarajo Bockenhauer, and Tricia H. Lucas, Esq, Advocacy Director for New Futures, Inc., also took part – encouraging nurses to become active advocates on healthcare issues – and explaining the important role that NHNA plays in that process.

Attendees then conducted "mock hearings", patterned after the NH legislative process, debating both sides of an actual bill. This year student volunteers from Colby Sawyer College and St. Joseph Nursing School prepared and presented 'testimony' on the Medical Marijuana bill. *Our thanks to those brave students and to their faculty advisors for taking part.* The event also includes guided tours of the State House and Legislative Office Building. Depending on bill schedules and other State House business, participants usually have the opportunity to observe an actual legislative hearing and have at least a brief meeting with the Governor.

NHNA is grateful to all the aforementioned participants in our 2013 Health Policy Days – and to other volunteers who acted as tour guides: Carlene Ferrier, Susan Smith, and Paula Hurvitz, as well as registration volunteer, Chelle Bergeron. Special thanks go to US Air Force recruiter T.Sgt. Lorna Allen for arranging breakfast sponsorship for each of the two events.

President-Elect Bockenhauer

Lea LaFave and Carlene Ferrier

Health Policy Days

One tour group

USAF TSgt. Allen

Susan Smart and Tricia Lucas

G. Blackmer and Atty. Dunn

Harding, Gilmour and Dunn

St. Joseph mock hearing students

President Joy and volunteers

Rep. Harding

NCC students with Gov Hassan

Executive Chambers

Medicaid Expansion in NH

The following was printed as an OP ED article from NHNA by over a dozen NH publications.

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As the President of the New Hampshire Nurses' Association, I have had many conversations with nurses around the state about the delivery of high quality health care. I have yet to have a conversation that does not conclude with someone stating the obvious – we have to figure out how to bring everyone under the tent so we can get serious about prevention.

Every nurse knows that prevention and personal responsibility are the keys to a healthy life and affordable health care. An apple a day, as our grandmothers taught us. So why is it so hard?

One Fund Boston collected over $25 million in one week to help cover the health care costs associated with the serious injuries suffered by dozens of innocent victims at the Boston Marathon bombings. Driven by the inescapable horror and our feelings of helplessness, we opened our hearts and our wallets. Good for us.

On a very basic level, we knew that helping victims get the treatment they needed was the best help we could give. Ensuring they get high quality care and can return home to their jobs and families gives them – and us – a way to heal from this tragedy. Fortunately, most health problems are neither as unexpected nor as horrifying as injuries from a terrorist attack.

Most health problems start small and our ability to get prompt, affordable treatment will decide whether that health problem is cured, controlled, or drives us into an emergency room in crisis in the middle of the night.

We, as a state, as a nation, face a real challenge in getting more people the care they need before they reach a crisis – bringing them under the tent.

New Hampshire has an opportunity, right now, to advance this laudable goal. Our House and Senate members will soon decide whether to accept federal funds allocated to our state to extend health coverage to thousands of people currently without health insurance.

For the next three years, the federal government is offering to pay 100 percent of the costs to insure, via Medicaid, more low income workers and their families.

Estimates suggest this would help as many as 58,000 Granite Staters by 2020. Starting in 2017, New Hampshire would gradually contribute toward the cost but never more than 10 percent under federal law.

Most of the people who would be helped by the expanded coverage are employed and hard-working, but they lack the education or opportunity to secure a position that offers health benefits. These are the people who build our houses, grow our food, and take care of our very young and very old.

To leave them outside the tent means they have no easy access to preventive care – no check-ups, no screening colonoscopies, no nutritional guidance or smoking cessation support. The irony about our current system is that these folks will get treatment in a crisis. New Hampshire hospitals support a robust system of financial assistance, funded largely by the premiums charged to those of us who are privileged enough to have health insurance.

Unfortunately, paying to care for someone with colon cancer is hundreds of times more expensive than paying for a colonoscopy that allows for early treatment to prevent the disease. Doctors and nurses cannot educate patients about prevention if they only see their patients when they are sick. In the end, we all pay for the lack of prevention.

Accidents and sudden health emergencies – even acts of violence – will unfortunately remain a risk for all of us and everyone deserves high quality care when disaster strikes. But we can also do more to contribute to our community's well-being – and reduce costs – by encouraging wellness and preventing disease.

The first step is to bring everyone under the tent. Taking the federal dollars to extend Medicaid to more people benefits us all and moves us closer to a health care system focused on prevention rather than crisis. That's why the New Hampshire Nurses Association supports the expansion of Medicaid and urges our lawmakers to do likewise.

Judith Joy, PhD, RN
NHNA President, 2013

NCLEX Bar Raised

The National Council of State Boards of Nursing raised the passing standard for the registered nurse licensing exam effective April 1, 2013. The NCSBN determined that safe and effective entry-level RN practice requires a great level of knowledge, skills and abilities than was required in 2009 when the standard was implemented.

Nursing Database Introduced

The National Council of State Boards of Nursing (NCSBN) has made licensure and disciplinary information publically available in one location. The National Nursing Database is update daily and provides the number of licensees and actions on licenses by state.

As of May 17, 2013 New Hampshire had 20,551 licensed registered nurses and 3,378 licensed practical nurses. These licenses represented 0.53% of the 4,518,263 licensed RNs and LPNs in the United States. In 2012 the New Hampshire Board of Nursing suspended 8 licenses, revoked 4 licenses and placed 14 individuals on probation. Website: https://www.ncsbn.org/3873.htm

Nurses Float a 2013 Award Winner

What is a nurse? That's the question posed on the nurses' float, "A Healing Place," that rolled down Colorado Blvd. on Jan. 1, 2013 in the 124th Rose Parade. The float won the Craftsman Trophy for "Exceptional Achievement In Showmanship & Dramatic Impact" for floats that are 55 feet or longer. It was the first float in the parade to honor nurses and in particular, the Rose Parade's 2012 President.

In 2007, a group of five Southern California nurses learned that Sally Bixby, RN would be the 2012 President of the Tournament of Roses. Bixby is the first RN and second woman to be the tournament's president in its 124-year history. The entry, "A Healing Place," was conceived as a way to bring attention to the profession of nursing and honor Bixby. The five nurses founded a non-profit and funded the float out of donations.

The float was filled with lifelike animals in a forest glade that provides a sanctuary. Around the base of the float, black letters listed the characteristics of nurses: caring, wise, conscientious, compassionate, gentle, confident. Animals on the float were metaphors for these and other characteristics. The doe and fawn represent the quality of caring and owls represent wisdom and conscientiousness. The rabbit represents fertility, which includes both the work nurses do in that area of medicine and recruiting, educating and nurturing new nurses. Intelligence and the compassion of nurses who work through the night are seen in the raccoon as it gently moves the turtle forward. The turtle calls to mind the patient's journey to health. The squirrel represents the commitment that nurses have to their patients, and the birds and butterflies create a supportive environment of "A Healing Place." Eight nurses and two student nurses rode on the float, representing a range of areas that nurses practice.

Florence Nightingale, the founder of modern nursing, had a presence on the float in the lanterns that authentically replicate the lamp she carried when she made nightly rounds during the Crimean War and in the three nightingales on a branch. She "sang loud and clear about what was needed to improve patient care in hospitals." Nightingale also had a pet owl, another reminder of the founder of nursing.

In My Opinion

On Altruism

Susan Fetzer, Editor

Hurricane Sandy, Sandy Hook, the Boston bombing, and the Moore, Oklahoma tornado. Two natural and two manmade disasters faced individuals who were unsuspecting and unprepared for the devastation, destruction, suffering and sorrow that occurred. At all of these events, nurses were there, quietly and competently doing what nurses do best. The seven NICU nurses from NYU Hospital worked efficiently to evacuate their patients when the East River flooded from Hurricane Sandy. On the ninth floor, the NICU lost power and the backup generator failed with two pound infants on ventilators. Working in teams, the nurses made it down nine flights of stairs, to waiting ambulances. The Sandy Hook school nurse was the first to call 911 and ask for help. A multitude of nurses cared for the victims and survivors of the Boston bombing. From the first at the scene, to the ER, OR, and surgical nurses who stayed long after their shifts were over to help their colleagues, their performance would have made Florence Nightingale proud. It was nurses who coordinated care to get the patient's from the ER to the OR in such record time. And even the most difficult assignment was the care provided by the ICU nurses assigned to one of the bombers. In a Boston Globe interview these ICU nurses all said that the ethical bedrock of their profession requires them to treat patients regardless of their personal history. All nurses have cared for drunk drivers, prisoners, gang members, but this assignment was perhaps the ultimate test of professional ideals. And most recently in Moore, Oklahoma, where at Moore Medical Center, a 45 bed hospital, nurses were forced to evacuate all of the patients to the protected basement cafeteria in 15 minutes. A Moore obstetrics nurse, having just assisted in a delivery, managed to get mom and newborn to the cafeteria and protected them through the tornado.

The media have labeled many of these nurses "heroes" and while they certainly deserve our admiration and commendation, in fact, they were doing nursing. Altruism is one of the guiding value and principles of nursing: the practice of concern for the welfare of others. It is often used interchangeably with selflessness. Altruism is required in a nurse-patient relationship, whenever or wherever it occurs. The disasters that have occurred have underscored the values of the profession. Altruism should never be taken for granted; but granted for the taking.

When asked why they chose nursing, many nursing students will retort "to help people." In the next few months, over 600 newly licensed nurses will enter the New Hampshire workforce. They will bring to the profession a renewed sense of altruism. They will face their own small and perhaps insignificant disasters as they learn from the seasoned pros. I hope you will find and rekindle the same altruism you had as a new nurse to mentor our new colleagues.

While altruism is a noble and critical characteristic of our profession, it does little to educate the public on the value of nursing care. How many of the four nurses' stories I described did you read or hear about in media coverage? How many do you think the general public heard about? We must tell our stories and specifically the impact of our altruism on patient and health care outcomes. If we do not, no one else will.

The New Hampshire Nursing News salutes all nurses who "step up to the plate" when little or large disasters strike. If you or a colleague made a difference, small or large, please write your or their story and share it. Altruism is alive and well in New Hampshire, but only if it is visible and voiced.

Hopes for the Future of the New Hampshire Nursing Workforce

New Hampshire Action Coalition:
Transforming Healthcare Through Nursing
FUTURE OF NURSING™
Campaign for Action

The New Hampshire Action Coalition (NHAC) has distinguished goals and objectives, that embrace the key messages put forth by the Institute of Medicine (IOM) in *The Future of Nursing: Leading Change, Advancing Health* report. Key message #4 states that "Effective workforce planning and policy making require better data collection and an improved information infrastructure" (IOM, 2011 p. 6). This key message has been addressed to date through the formation of an NHAC Workgroup whose members have successfully implemented a nursing survey collecting the minimum data set through cooperation with the Board of Nursing. This survey can be accessed and completed by licensed nurses at the Board website: http://www.nh.gov/nursing/data-collection.htm.

The NHAC Steering Committee met in February 2013 for a bi-annual meeting. A team of stakeholders, including members from the Diversity Pipeline Project Advisory Committee; who are also recipients of Robert Wood Johnson Foundation Partners in Nursing IV (PIN IV) funds; presented to the NHAC Steering Committee a plan to include Diversity as an official Workgroup of the NHAC. Their proposal was accepted. In late February 2013, the NHAC co-leads attended the Campaign for Action National Summit in Washington, DC and returned from that meeting with a basic action plan which clearly identified the need for a formal structure to collect and analyze nursing data. These two actions, the adoption of a Diversity Workgroup and the identification of the need for a formal data collection plan provided the jumping off point to consider the development of a Center for Nursing Workforce.

Following return from the National Summit, the NHAC Executive Committee met to consider the developed action plan and it was determined that priority actions would be to convene a strategic planning session and explore moving forward to revive a nursing workforce center in New Hampshire. A New Hampshire Center for Nursing Workforce previously existed in the state but became inactive due to lack of funding and human resource challenges in 2009. The NHAC Data Workgroup convened to further assess feasibility of this proposal. The action item that arose from the Executive Committee and Data Workgroup recommendation was to extend communication to all NHAC Steering Committee members to ascertain level of need, engagement and interest in reviving a workforce center. The Steering Committee member's responses indicated strong support for the revival of the nursing workforce center.

The Executive committee convened an ad hoc strategic planning group comprised of the key stakeholders involved in diversity and data collection activities from the state to review the initial priorities, the work plan developed at the National Summit which included plans to revive the New Hampshire Center for Nursing Workforce with a tentative plan to apply for Robert Wood Johnson Foundation State Implementation Plan (RWJF SIP 2) funds.

On June 4, 2013 a full grant proposal was submitted to RWJF to apply for SIP 2 funds. The action plan set forth in the grant proposal is two-pronged: 1) Re-Establish the New Hampshire Center for Nursing Workforce as a way to 2) develop a data collection and analysis infrastructure in support of all other IOM recommendations.

If funded, the New Hampshire Center for Nursing Workforce will bring together New Hampshire nursing organizations and other diverse stakeholders including the New Hampshire Hospital Association, Area Health Education Centers, the Primary Care Workforce Commission, AARP, academic partners, foundations, and healthcare agencies. The collaborations made possible through this infrastructure will enhance the existing Action Coalition work and strengthen efforts to address additional IOM recommendations.

Our Action Coalition seeks to leverage the center and the data collected to support the diversity components of the IOM recommendations. Through the work to build a data infrastructure in New Hampshire the Center will seek to establish nursing supply, demand, and education data within the state that will assist in assuring an adequate supply of ethnically diverse, highly qualified nurses to meet the health needs of New Hampshire residents. These data will assist the New Hampshire Action Coalition in pursuit of its goal to transform the future of nursing in New Hampshire.

NHAC Executive Committee:

- The NH Organization of Nurse Leaders (NHONL) represented by Linda J. von Reyn, PhD, RN Chief Nursing Officer–Dartmouth Hitchcock Medical Center
- NHNA represented by Sandra McBournie, RN, BS, M.Ed. – Plymouth State University
- Nursing Champions represented by Shawn LaFrance, Executive Director–Foundation for Healthy Communities (FHC) and Kelly Clark, State Director, AARP – New Hampshire

For more information on the Center to Champion Nursing in America go to http://championnursing.org/CCNA-overview-2010. You can find more information on the NHAC and join the conversation at http://campaignforaction.org/state/new-hampshire

Would you like to get involved in the New Hampshire Action Coalition? We would love your hand and your voice! Contact us at NHActionCoaltion@gmail.com

Reference:
IOM, (2011). *The Future of Nursing: Leading Change Advancing Health*. The National Academies Press, Washington: DC.

NHNA Student Conference

On April 19th some 280 graduating nursing students from schools around New Hampshire came together for **"From SimLab to Successful Practice"** at Nashua Community College in Nashua. The day was designed to provide information and tools for the transition from student nurse to the 'real world' nursing workforce. Many thanks to each of our volunteer presenters for sharing their expertise and making this day a reality.

Melinda Luther, Chair of the nursing program at NCC, welcomed everyone to the conference. *We are grateful to the college for allowing the use of their facilities and staff support to help the day run smoothly.*


Margaret Franckhauser

NHNA President, Judith Joy, PhD, RN, next shared opening remarks of encouragement and introduced our Keynote presenter, **Margaret Franckhauser, MS, MPH, RN** – CEO of Central NH VNA and Hospice. Ms. Franckhauser laid out **"Keys to Finding Your First Job in a Tight Economy."** She emphasized the importance of distinguishing yourself with any special skills/attributes that could provide an edge in a competitive job market. She encouraged flexibility: taking per diem work to gain experience and get a 'foot in the door' to show employers solid skills and reliability/ worth ethic; looking at opportunities beyond acute care; considering military options or moves to other parts of the country that are still in nursing shortage situations, and working on that next degree if at all possible. ***"Excellent speaker and I left feeling invigorated about the road ahead, not scared."***


Margaret & Judy

The group then split into concurrent breakouts for the next three time slots *and in between sessions visited our many exhibitors.*

"Taking the Fear Out of Pharmacology" with **John Foley, Pharm.D.** helped participants to: understand drug interactions by grouping similar medications; identify high risk/high alert medications; outline simply safety routines for med administration; list key considerations when giving a medication for the first time; predict, avoid and manage side effects, and list reliable resources for drug information. ***"Wonderful speaker – really funny - and provided us with useful information that will aide us for the upcoming NCLEX exam."***


John Foley

"Self Care for Success in Nursing Practice" was shared by **Ann Fournier, PhD(c), MS, MSN, RN, ACNP-BC, AHN-BC, CNE.** Participants explored the expectations and realities of professional practice; the need for self-care for successful transition to practice: and a variety of self-care modalities. ***"Ann made this session fun to listen to and presented the information in a way to stress the importance of self care."***


Emerson & Joy

"Getting Hired:" Brandi Emerson, PHR and Talent Manager for Concord Hospital, presented valuable resume and interviewing tips plus other insights on what employers are looking for in making hiring decisions. ***"She was such a valuable resource and so many people had great questions."***

"What Comes Next: Professional Development" with **Susan Fetzer, PhD, RN** covered the "professional imperative" of lifelong learning for nurses – especially since the estimated half-life of nursing knowledge is less than 12 months without keeping up with new practice information. The session covered continuing education required for re-licensure and suggested sources; the value of advanced certifications, and the importance of continued formal education toward that next degree.


Susan Fetzer

In the next time slot, Dr. Fetzer also presented: **"Shifts Happen"** discussing the pros, cons and physiological issues surrounding shift work – plus key measures to maintaining health and balance including adequate light, sleep, diet and activity.

"Difficult Workplace Communications" – Jodi Boutwell, MS, APRN, FNP-BC, explored managing uncomfortable situations, difficult conversations *and people* in the workplace – as well as how to develop "hardiness" and resilience in the face of adversity and challenge.

"Critical Thinking for the New RN" – Kate Collopy, PhD, RN covered a variety of models, resources and tools for clinical decision-making as one progresses from novice to expert. ***"Extremely helpful in order to recognize what critical decisions may be necessary to make as soon as we get into the world of nursing."***


Kate Collopy

"Your First Year – Surviving and Thriving" was presented by three nurses within 5 years of graduation who have navigated the transition from school to successful practice. **Amanda Callahan, RN, BSN, MBA** (St. Joseph Hospital), **Nancy Merlino, RN, BSN** (CMC), **and Grace St. Pierre, BSN, RN-BC** (DHMC), shared their own stories and tips and answered audience questions. The panel discussion was moderated by **Destiny Brady, MSN, RN, CCRN** (St. Anselm College). ***"Speakers were very helpful and had a lot of good advice going into my first job."***

"End of Life Issues for the New RN" with **Rita Anger, MSN, RN**, discussed comfort care for the dying as an integral part of nursing care; understanding of compassionate and effective communications with the patient, family and healthcare team; recognition of symptoms experienced by patients at the end of life; recognition of one's own attitudes/ feelings about death and the individual. ***"Great session – I wish they would cover more on this in school."***


Denise Nies & Rita Anger

- I was happy to have the opportunity to attend this conference. I am definitely thinking about becoming an NHNA member in the future, and am appreciative for the tips I received today.
- I think this conference will help guide me through my first year as an RN!
- This was my first conference and I found it a nice and informational experience.
- Much better than I expected.
- Any conference that I can attend to enhance my learning and knowledge towards my career is greatly appreciated!
- I really enjoyed the day and am glad there is a CD I can review to see what I missed [from the other] sessions.
- Nice networking opportunity.
- Thank you for putting together a great conference.
- I enjoyed this conference and now feel more confident as a result of all the helpful information I learned.
- I wanted to go to all the sessions so the CD was awesome to be able to see everything that I couldn't go to.
- Great Experience!
- The CD was a great idea… having information from each speaker was very helpful!
- The location was wonderful; I'd never been to NCC and it was beautiful. I also prefer having the CD in order to be able to access information from each session including those I was not able to attend.

"Scope of Practice and RN Delegation" with **Denise Nies, MSN, RN, BC – Executive Director of the NH Board of Nursing**, helped strengthen student understanding of the nurse practice act that governs practice in NH and the legislative process that affects nursing practice. Also discussed was nursing delegation as outlined in law and the administrative rules.


Kathie Poplar

"Creating Partnerships in Practice" with **Kathie Poplar, RN, MSN**, helped participants gain an understanding of: the importance of asking questions and establishing resources; taking constructive criticism; partnerships between nurses and LNA's, and commitment to co-workers. ***"This session was very helpful for me because as a student I've always been intimidated to talk to doctors, but this showed me the importance of utilizing my team as a resource."***

"Stay Calm & Get the Crash Cart" was another panel discussion, moderated by President Joy, including presenters **Boutwell, Collopy and Fournier** mentioned earlier, plus **Victoria Hudson BS RN, PCCN**. The panel shared words of wisdom from their years of experience and answered audience questions. ***"Really appreciated getting the perspectives from so many experienced nurses."***

The day ended with a prize raffle and many students went home with goodies surpassing the value of their conference registration – *including a Kindle Fire HD – donated by the NHNA Board of Directors.*

Our thanks to conference sponsors: A. L. Davis Publishing; Sanofi Pasteur, Walden University, Catholic Medical Center and Elliot Health System and our other exhibitors: Alexander's Uniforms; Genesis Healthcare; Gideon International; Huggins Hospital, NH

NHNA Student Conference continued on page 7

NHNA Student Conference continued from page 6

Vicki Hudson, Kate Collopy, Ann Fournier and Jodi Boutwell

Action Coalition; NH Hospital; NH DHHS Departments (Asthma Control, Diabetes Education, Immunization, and Tobacco Prevention and Control); Plymouth State University; Rivier University; Saint Anselm College, Saint Joseph's College Online; Sanofi Aventis and Southern NH AHEC.

Recent grad panel: Brady, Callahan, St. Pierre and Merlino

Planning volunteers: Amanda Callahan, Nancy Merlino and Grace St. Pierre (see 'Your First Year' panel). **And additional event day volunteers: Destiny Brady, Bonnie Kershaw and Joe Desjardins.**

Genesis

Gideons

In Memory of Our Colleagues

In Memoriam

NHNA is pleased to honor deceased nurses who graduated from New Hampshire nursing programs and/or practiced in New Hampshire during their nursing careers.

ICU Nurse

Beverly G. Vandenburgh, 74, passed away February 10th, 2013. Born in New York she was a BSN graduate of Ohio State University in 1955. She was a volunteer EMT, a nurse in the ICU at southern New Hampshire Medical Center (Memorial Hospital) in Nashua, a high school nurse in Milford and a Health Services Nurse at Digital Corporation.

Beverly G. Vandenburgh

Maternity Nurse

Ruth Dunlap Dodge, 91, died February 15, 2013. She attended Children's' Hospital School of Nursing in Boston and the University of New Hampshire. In 1945 she graduated from Newton-Wellesley School of Nursing in Newton, Mass. During her professional career, she practiced at the former Memorial Hospital in Concord, Concord Hospital, and the Concord Clinic. She especially enjoyed her time in maternity nursing caring for newborns and their mothers.

2009 Clint Jones Award Winner

Joan (Corbeil) Hubbard, 59, died February 19, 2013 at her home. For a second career, Joan graduated with her Associate's degree in nursing from the NHTI Community College in Concord and practiced for several years as a staff nurse at Concord Hospital. Joan was awarded the Clint Jones Nursing Award in 2009 by the Foundation for Healthy Communities for her exceptional commitment to high-quality patient care and to the nursing profession.

Joan Hubbard

Short Career

Tracy A. Rose-McKeon, 42, died February 20, 2013, after a valiant fight with colon cancer. She was a 2012 graduate of the Lakes Region Community College with her associate degree, serving as the co-president of the nursing class. In 2011 she received the President's Award of Excellence. She was a nurse with Concord Family Medicine.

Tracy Rose-McKeon

Danish Nurse

Jette F. Tinker, 74, died February 22, 2013 of the complications from multiple sclerosis. Born in Denmark and witnessing the occupation during WWII she graduated from nursing school. She relocated to New Hampshire in 1969 and practiced at the Alexander Eastman Hospital (Parkland Medical Center) as a coronary care unit registered nurse.

Jette Tinker

50 Year Career

Norma A. (Nute) Roy, 88, of Manchester, died February 27, 2013, after a brief illness. A New Hampshire native during World War II, she served in the U.S. Army. She later earned a degree in nursing from the Elliot Hospital School of Nursing and earned additional college credits from Notre Dame College in Manchester. She was a member of the Elliot Hospital Nurses Alumni Association and practiced at the Elliot hospital for 50 years before retiring.

Norma A. Roy

College Nurse

Edna Harvey Woodward, 89, passed away on March 11, 2013. An Epping native she attended Nursing School at Peter Bent Brigham Hospital in Boston, Mass. In 1944, she joined the Army Nurse Corps serving in Japan and the Philippines. After the war Edna earned her BS in nursing at the University of New Hampshire where she met her husband. She practiced nursing at UNH for 30 years retiring in 1987.

Wound Ostomy Nurse

Marie T. (Forgue) Gavin, 63, died February 27, 2013. Marie furthered her education and graduated from Fitchburg State College where she received her degree in nursing. She became a registered nurse and furthered her education at the Sloan Kettering School in New York City. In 1975, Marie went to work as a registered nurse at the Veterans Affairs Medical Center in Manchester and retired December, 31, 2011.She was a member and longtime secretary of the Wound Ostomy Association.

Marie T. Gavin

Seacoast Nurse

Thelma Hazel (Hamilton) Toof, 83, died March 9, 2013. A Dover native, she graduated from the Wentworth Hospital School of Nursing in 1950 as an RN. She continued to work at WDH, retiring in 1982. She primarily worked as a maternity nurse delivering the babies of many of her family and friends. She was a member of the Alumni Association of WDH and ANA.

Thelma Toof

US Cadet Corps

Eloise Ruth Bickford, 87, passed away March 13, 2013. Born in Massachusetts she was a 1948 graduate of the US Cadet Nursing Corps. Her first nursing job was as summer camp nurse for Birch Hill Camps. She also practiced as a staff nurse at Frisbie Memorial Hospital medical - surgical floor, and later became the office nurse for 11 years for Dr. Robert E. Lord of Farmington. While helping others as a nurse was Eloise's first calling, she was also called to serving her community. New Durham voters elected her as the town's first female Selectman serving from 1976 through 1983.

Eloise Bickford

Labor and Delivery Expert

Frances E. "Fran" (Patten) Janas, 85,died March 17, 2013. She graduated from the Elliot Hospital School of Nursing in 1948. She was well known for her work as a labor and delivery maternity nurse. She was instrumental in promoting natural childbirth and having fathers participate in the labor and delivery process. She developed the Janas Tilt, a procedure for posterior presentation that is documented in medical journals. After her retirement from Elliot Hospital, Mrs. Janas worked closely with Dr. Edwin Childs as an office nurse. She was actively involved in the education of parents with babies born with cleft lip and palates, teaching how to feed and techniques for proper speech development.

Frances Janas

Supported Parents after Miscarriages

Diane F.(Mathers) Fox, 65, of Milford, NH died on February 21, 201. Diane graduated from New Hampshire Hospital School of Nursing, Concord, and later earned her Bachelor of Science in Nursing from Rivier College. She had been employed as a Registered Nurse at St. Joseph Hospital for more than 30 years in the maternal child health department. In addition, she worked at Aynsley Place, Nashua, NH for several years. She was instrumental in establishing Empty Cradle, a support group for parents who lost their children through miscarriage or stillbirth.

Advocate for Young and Old

Maxine Agle Osgood, 97, of York, Maine, and Sarasota, Fla., died March 24, 2013. A native of New Hampshire she attended the University of New Hampshire and the Pillsbury School of Nursing in Concord, N.H., where she earned her Licensed Practical Nursing degree. She practiced as an LPN at the New Hampton School for Boys, the Speare Memorial Hospital in Plymouth, New Hampshire and at the Plymouth Harbor Retirement Community in Sarasota, Fla. After retiring she completed the training requirements and participated in the State of Florida Guardian Ad Litem Program. This allowed her to represent the best interests of abused and neglected children in court proceedings. In addition she was a trained participant in the State of Florida Long-Term Care Ombudman's Program. She advocated for people living in nursing homes and assisted- care facilities.

DHMC Nurse

Michele D. Kettwig, 60, died March 27, 2013. After receiving her nursing degree in Pennsylvania she practiced nursing for many years at Dartmouth-Hitchcock Medical Center in Lebanon, NH and later for Jarit Instruments. Most recently she had been employed by Case Medical as a Nurse Consultant.

Michele Kettwig

Corrections Nurse

Eleanor Janette (Page) McCullough, 77, died March 28, 2013, in Dover. Eleanor was an associates degree graduate of the Stratham Vo-Tech (Great Bay CC). She was a longtime nurse at the Rockingham County Jail in Brentwood.

Eleanor McCullough

Mary Hitchcock Grad

Shirley Evelyn (Huckins) Noyes, 82, died April 2, 2013 in Keene. Shirley attended the University of New Hampshire and graduated from Mary Hitchcock Memorial Hospital Nursing School as a Registered Nurse. She was dedicated to her work and her patients and worked at MHMH, now Dartmouth Hitchcock Medical Center, for over 23 years.

Notre Dame Grad

Charlotte (Salem) Mullavey, 96, died April 2, 2013, at Portsmouth. She was a graduate of the Notre Dame Hospital in Manchester where she also practiced as a nurse.

Charlotte Mullavey

CMC Nurse

Elizabeth E.(Smith) Simonds, 81, died April 12, 2013 in Dover. She retired from Catholic Medical Center in Manchester where she had been a nurse for many years.

Oncology Nurse

Kathleen (Kontje) Healey, 70, of Nashua, died April 13, 2013. A New Jersey native she practiced as a registered nurse at the former Memorial Hospital (now Southern NH Medical Center) from 1975 through 1990. She continued her career as an oncology nurse with the Dartmouth Hitchcock Clinic from 1990 until retiring in 2005.

Laconia Hospital Grad

Mary McDonald Davis passed away on April 28, 2013 in Florida. A Maine native she graduated with a nursing diploma from the Laconia Hospital School of Nursing in 1965. She practiced as a nurse for many years at the Laconia Hospital and then raising a family she worked part-time doing insurance physicals.

Mary Davis

ER and Long Term Care Nurse

Constance Janet (Gill) Perrins, 80, of Bedford, died April 29, 2013. A Manchester native she attended nursing school in Nashua. She and her husband Bill established and ran Woodcrest Nursing Home. Later, she practiced in the ER nurse at Elliot Hospital.

Constance Perrins

Nashua Nurse

Constance Evelyn (Dawson) Bartlett, 95, died Sunday April 7, 2013. She practiced nursing various hospitals in Massachusetts and at Memorial (SNHMC) and St. Joseph's Hospital in Nashua, from which she retired after many years.

Constance Bartlett

In Memory continued on page 9

In Memory continued from page 8

St. Anselm Grad
Barbara (Paul) Ryan, 61, passed away peacefully at her home on May 1, 2013, after a prolonged illness. After attending Saint Anselm College, Barbara spent many years as a nurse in the Manchester area.

Barbara Ryan

WWII Evac Nurse
Rae (Parmenter) Sives, 90, passed away on May 1, 2013. A Derry native she received her diploma from the New England Deaconess Hospital in Boston, as a registered nurse in October 1943. Rae served her country proudly as a lieutenant from August 1944 to February 1946 and was assigned to the 112 Evacuation Hospital during World War II in France and Germany. After the war she was a school nurse for Londonderry, Chester, Auburn and Windham elementary schools for many years until 1968.

Rae Sives

Discharge Planner
Florence E. "Flo" Lagasse, 78 passed away May 5, 2013. A Maine native she practiced at the Elliot Hospital in Manchester and was a nursing instructor at Beverly Hospital from 1964-1990 and in 1991 was the discharge planner at J.B. Thomas Hospital in Peabody, Massachusetts.

Florence Lagasse

First CCU Certified Nurse
Patricia A. (Bolduc) Molloy, 79, died suddenly May 9, 2013. Patricia graduated from the Sacred Heart School of Nursing. She was one of the first seven certified coronary care nurses in the state of New Hampshire in 1966. She then pursued teaching coronary care throughout the state. Molloy was the associate director of Nursing Service at Catholic Medical Center in 1970. She was a forerunner in the Physicians Peer Review Program in the mid to late 1970s and later developed the first quality assurance program for all departments at the Catholic Medical Center, excluding nursing service, in 1981-82. She was president of the N.H. Council of Catholic Nurses.

Patricia Molloy

Elliot Hospital Grad
Barbara C. (Cooper) Miller, 82 of Manchester, died May 15, 2013. A Manchester native she graduated from the Elliot School of Nursing in 1950. She worked as a nurse in Manchester, Boston, Indiana and Louisville, Ky., and returned to Manchester in 1981.

School Nurse
Shirley Highter Mitchell died May 15, 2013, after a short illness. She received her nursing diploma from the Notre Dame School of Nursing in Manchester. She practiced at Springfield Hospital in Vermont and for the VNA in New Britain, Conn. After raising her children, she returned to nursing, serving as the nurse at Pembroke Academy until her retirement in 1995.

Shirley Mitchell

Reflections of a Student Nurse

Ed Note: The perspective of a student nurse can give even the most experienced nurse a reason to pause and reflect. Reflection allows us to learn and grow.

Yesterday, I was lucky enough to have an experience I know I will always remember. It was an experience I always thought I'd be able to handle without difficulty, but in reality it was not easy for me to handle, not by a long shot. In fact, I'm still struggling with the situation, desperately wishing there was more I could have done.

One of our four patients assigned to my preceptor and I was a CMO patient. CMO stands for "Comfort Measures Only", an abbreviation I had never heard before. This patient was an eighty-eight year old woman who was brought to the hospital because she was exhibiting signs and symptoms of a stroke. After admission, a severe UTI that had caused her to become septic. To put it simply, the patient's prognosis was not promising and within a few days, the patient had become unresponsive. With this news, the family had decided to forgo treatment and make her CMO. Now it is important to mention that by the time my preceptor and I were assigned this patient, she had been on CMO for 3 days, an agonizing and exhausting experience for the family who refused to leave her side.

On the night shift before we arrived, the patient had begun to experience seizures that were focused in her face, specifically her jaw area. The seizures looked like the patient was chewing gum really fast. The night nurse had received an order for IV Keppra in hopes it would prevent the patient from having seizures. As you can imagine, the patient's family, especially her husband, became incredibly anxious every time a seizure occurred. Unfortunately, the medication was not successfully preventing all the seizures and we witnessed five or six seizures in the twelve hours we worked with this patient and her family.

Throughout our shift, the patient also experienced epistaxis as well as high fevers. We worked all day to help fix these problems but it seemed no matter what we did, she was not comfortable. She was on a Morphine drip for discomfort, was receiving Keppra for seizures, given PRN Morphine boluses, PRN Tylenol, and PRN Ativan. By the end of the shift, the patient seemed more comfortable, but it was one of those situations where you wish there was more that could have been done.

Although the patient's condition was interesting and incredibly important to my experience, I want to focus on my feelings throughout that day. I've experienced death many times throughout my life. I've watched close family members deteriorate and pass away, I've witnessed the traumatic death of a close family friend, I've held the hands of dying patients and their family members while working as a Licensed Nursing Assistant, and I've performed post mortem care in clinical as a nursing student. However, these experiences did not prepare me for the emotions I felt this time.

The family shared, on several occasions, their readiness for their wife and mother to pass away. I, too, felt myself wishing the same exact thing. I found myself finally understanding Physician-Assisted Suicide, a topic we discussed in Medical Ethics class. At the time, I was disgusted and horrified with the thought that a physician could willingly kill a patient no matter how much distress the patient was experiencing. Now I truly understand how physicians are able to do this and I wish I could have done this for my patient. I found myself desperately wanting to take away the woman's pain and suffering. She did not deserve this discomfort and I felt as though I was withholding my help by allowing her to go through it. We tried our absolute best in making her comfortable and nothing seemed to work. It was clear the patient's family was ready to let her go, but it was also clear the patient was not ready to let go herself.

Before leaving, my preceptor and I discussed the importance of telling the patient that it was okay to let go. Turns out, the husband had not directly told his wife that it was okay for her to leave. He asked us to stay with him as he did so and it is the first time I have openly cried with a patient and/or a patient's family. It was so clear how close this family was and the love and support they had for each other. It was an experience that still brings me to tears when I think about it, it probably always will. I wish I could say the patient passed away at that very moment, but she did not. I only hope she did not suffer much longer and that she found peace.

So, I end this journal with a question, a question I've been trying to answer since I walked off the unit that night. How do I handle a situation like this? Did I handle this situation right or wrong? Is there even a right answer? I feel guilty for even wishing I could end the patient's life. Is that a normal reaction in nursing? My preceptor assured me that it was, but I'm still not so sure. Is it acceptable to openly cry in a patient's room? I know that nurses are only human and this is bound to happen, but, at the same time, I believe patients and patients' families look to us for the answers and expect us to be strong in all situations. There is no way I could have been strong in this situation, I know that for a fact. What do you do as a nurse when there are situations you just cannot handle? Do you excuse yourself from the room, or do you allow the patient and the patient's family see you weaken? Is it healthy to be constantly thinking of a patient you had during a shift and wishing you had done more and actually feeling guilty for not doing more?

I know there isn't an easy way to answer these questions, but how do other nurses handle these situations? Am I feeling the way I am because I am a "new nurse" or is this feeling one that all nurses, no matter how many years in the profession, experience? I can honestly say I would not have guessed I would feel the way I do if I had been presented with this situation before it actually occurred. I'm not expecting to have the answer to all these questions, or to any of them for that matter. I just present them as a way to clear my head and demonstrate what I've been internally debating since the end of my shift. This is definitely one of those topics that cannot be taught in class or read in a textbook. Perhaps I'll bring this topic up in class tomorrow afternoon.

Melissa Laurion was a senior nursing student at St. Anselm College when this journal entry was written and recently graduated.

Member Spotlight

Continued from our Spring issue – Nursing News will be sharing the career stories of the members of our Commission on Nursing Practice.

Candace Stillman, MSN, RN

During the 70's I was contemplating what I wanted to do with my life. I could not make up my mind if I wanted to be a teacher, social worker or a nurse. I was very clear that what ever I did, it was to "ease the suffering." I volunteered as a "candy striper" at a local nursing home thinking the experience might assist me in the decision making process. The experience did not sway me in any specific direction so as I continued to contemplate my dilemma; I started college in a generic liberal arts degree.

In the meantime, I married and started having babies. I completed my liberal arts degree but was haunted by a feeling that I was not following my intended path. An opportunity became available to become a CNA (certified nursing assistant) which opened up a multitude of experiences with patient care. It became very evident to me that nursing was the right career choice. The long term care environment exposed me to incidents that were substandard in patient care. Having reported many of these incidents without seeing the expected changes in the facility, I felt that I needed the "power" of a nursing degree to make a difference.

I started nursing school in the 80's during a time when frequent moves were occurring in my life. I started Fundamentals of Nursing in Michigan and finally finished my ADN (Associates Degree in Nursing) in Maryland. Every move required applying to a new school and meant losing some credits (usually the sciences) that had to be re-taken.

As I was nearing the end of the ADN program, I was clear that I wanted to go on in my education. I chose a sterling silver pin to represent that I was going on for a gold pin. Immediately after graduation, I enrolled in the University of Maryland's RN to BSN program. I also was working at a big Baltimore hospital as a CNA in a cardiac step down unit while I was completing my ADN. This opened an opportunity for my first job as an RN.

Another move to New England occurred before completing my BSN. As soon as I arrived in our new home, I applied to schools to complete my degree. Working full time as a visiting nurse, a husband and four children, I began classes at Rivier. This degree was finally completed in 1996 and I now had that gold nursing pin.

Opportunities to do various types of nursing began to occur in my career (employee health, occupational health, nursing in a rehabilitation unit and a physician's office). I noticed I was doing a lot of social work and teaching. I find it amusing that I had such a hard time choosing a career field and ended up with one that included all my heart's desires. The biggest opportunity that opened up a whole new world for me was teaching nursing students. I realized that I loved being in the classroom with the students and decided that this was an avenue that I wanted to pursue. In 2007 I started a MSN (Masters of Science in Nursing) with a focus on Nursing Education. I completed the degree in 2010.

It never ceases to amaze me how it appears that every educational decision and every career opportunity I have had prepared me to be in the class room and clinical setting with nursing students. My diverse history has opened up my understanding of different learning styles, different cultural backgrounds and the difficulties facing students as they pursue their dreams of nursing.

NOTE: Candace (right in photo) is sadly leaving us and relocating to the sunny southwest! At her final meeting with the Commission she was presented a framed certificate of appreciation by Nursing Practice Chair, Bonnie Kershaw (left).

Kudos

Katie White, RN, is the recipient of the **2013 Clint Jones Nursing Award**. White practices at the Women & Children's' Center as a pediatric nurse at Wentworth Douglass Hospital. "Although Katie has only been working at Wentworth-Douglass for three years, the impact she has made has been significant," said fellow nurse Julie Cole in her letter of nomination. "On a daily basis, she demonstrates professionalism, sharp critical thinking skills and a superb bedside manner, and she demonstrates great potential to continue to be a leader in advancing the nursing profession." The Clint Jones Nursing Award was created in 2006 by the Foundation for Healthy Communities to honor the memory of the former director of the Foundation's N.H. Nursing Workforce Partnership. The award recognizes a registered nurse practicing in New Hampshire for at least one year but not more than six years, who exemplifies quality nursing care and demonstrates a commitment to a career in nursing.

Congratulations to **Lindsay Goff, RN, Leslie Bryan, LPN, and Lori Fox, APRN**, who were recipients of the Secretary's Award for Excellence in Nursing from the VA Medical Center.

Nurses in the News

Deborah McCarter-Spaulding, RN, PhD, recently received a research grant from the Alpha Chi chapter of Sigma Theta Tau International to support her study on the "Effectiveness of a Nurse-administered Educational Intervention in the Reduction of Symptoms of Postpartum Depression." Dr. McCarter-Spaulding is a faculty member at St. Anselm's College.

Julie Cole, BSN, RN, CPN, CLC, Clinical Educator Pediatrics at Wentworth-Douglass Hospital presented a paper at the 23rd Annual Society of Pediatric Nursing in Nashville, Tennessee "It Takes a Village: Collaborating to Overcome Challenges of Pediatric Nurse Orientation at a Community Hospital."

Faculty of St. Anselm's College presented posters. **Catherine Fogg, RN, PhD**, presented a poster entitled "From Frustrating to Rewarding: Nurse Practitioners' Experience Providing Voluntary International Humanitarian Service" at the National Conference for Nurse Practitioners in Nashville, TN. **Caryn Sheehan, RN, DNP, Katheleen Perrin, RN, PhD, and Laurie Bennett, RN, MSN**, presented "Engendering empathy in baccalaureate nursing students" at the 21st Annual Conference for Nurse Falmouth, MA.

Becky Sherburne, RN, and David Merriman, RPH, BS Pharm, MA, presented "Drug Diversion: The Role of the Nurse Leader" at Advanced Leadership series held in Manchester, NH. Sherburne is a nurse manager and Merriman the Director of Pharmacy at Wentworth-Douglass Hospital.

SAVE THE DATE!

NH NURSES' ASSOCIATION 2013 Awards Banquet:

Nurses
Many Roles One Profession

Wednesday, October 16th 6:00 pm Holiday Inn - Concord

(Following the NHNA Annual Member Meeting at 5:00 p.m.)

This event is meant to recognize and celebrate not just individual award winners, but the nursing profession itself - and all its many specializations.

Watch our website for further details: **www.nhnurses.org**

Sponsorship / exhibit opportunities available.

For awards to be conveyed - see Call for Nominations below.

CALL FOR NOMINATIONS

- **DIRECT CARE NURSE of the YEAR** - awarded to a registered nurse who exemplifies strength and passion as a professional nurse in clinical practice using best practice standards, patient advocacy and community involvement. This nurse is highly regarded as a leader among peers.

- **PROFESSION ADVANCEMENT** - given to a registered nurse who has made a significant contribution towards developing or advancing the professional practice of individuals or groups, or the art and science of nursing. The contribution may be in one or more of the following categories: Education (academic setting, staff development or other); Nursing Research; Evidence-Based Practice; Leadership, or Mentoring.

- **NURSE LEADER of the YEAR** - awarded to the New Hampshire Nurse Leader who positively impacts her/his health-care organization by converting the challenges encountered in the workplace into great opportunities using leadership skills. Eligibility for this award includes those employed in leadership roles as well as those who volunteer for leadership positions within organizations.

- **CHAMPION of NURSING** - for an employer/institution or individual who has had a positive impact on the profession of nursing. This employer/institution or individual will have contributed by demonstrating characteristics and/or practices that support individual nurses or the nursing profession.

PLEASE DOWNLOAD THE FULL INSTRUCTIONS FOR SUBMISSION FROM www.NHNURSES.org

Nominations for these categories are due by September 1, 2013

About NURSES

Somebody asked: "You're a nurse? That's cool, I wanted to do that when I was a kid. How much do you make?" The nurse replied: "HOW MUCH DO I MAKE?
... I can make holding your hand seem like the most important thing in the world when you're scared.
... I can make your child breathe when they stop.
... I can help your father survive a heart attack.
... I can make myself get up at 5 a.m. to make sure your mother has the medicine she needs to live.
... I work all day to save the lives of strangers.
... I make my family wait for dinner until I know your family member is taken care of.
... I make myself skip lunch so that I can make sure that everything I did for your wife today is charted.
... I make myself work weekends and holidays because people don't just get sick Monday thru Friday.
... Today, I might save your life.
... How much do I make? All I know is, I make a difference.

Re-post not only if you are a nurse or you love a nurse, but most importantly, pass this along if you respect their work.

On the Bookshelf

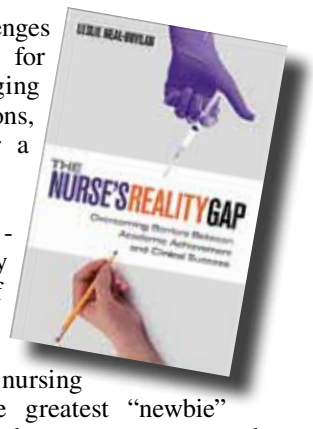
Reviewed by Alex Armitage, MS, CNL, APRN-BC, FNP

Alexandra Armitage is a Nurse Practitioner and a certified Clinical Nurse Leader, specializing in neurology and neurosurgery; bringing evidence-based practice to the bedside to improve patient care, patient outcomes and institutional viability.

The Nurse's Reality Gap: Overcoming Barriers Between Academic Achievement and Clinical Success
Leslie Neal-Boylan, PhD, CRRN, APRN-BC, FNP
Sigma Theta Tau International (2013) Paperback, 172 pages

Approximately one fifth of registered nurses are not practicing as nurses. Limited staffing, long work hours and non-competitive pay are often cited as the reasons that nurses leave their profession. But it this the whole reason there is such low retention? This book opens the discussion around a much more controversial reason: perhaps we are not training students in a manner that prepares them for working as a nurse. Dr. Neal-Boylan notes that today's nursing student is graduating with less confidence, less independent function, and little sense of accountability in the workforce.

The Nurse's Reality Gap takes a deeper look at how nurse faculty members fail to prepare students for the clinical world. It also challenges students to be accountable for this transition, by acknowledging the problems, offering solutions, and suggesting guidance for a smoother passage.



Written with first-hand accounts from newly graduated nurses, the voice of nursing rings clearly in each story. Each section of the book (divided according to nursing degree) details some of the greatest "newbie" challenges for the associate-degree nurse to graduate trained nurses. My greatest take home message from this book was the enlightening realization that at each level of education (irrespective of prior nursing experience) there is a chasm that a new graduate has to cross and it does not get easier with more advanced training. As an almost professional student I found this information strangely encouraging, as it allowed me to level my experiences with others. Ultimately, however, this is a book written for those educating the next generation of students. The ultimate goal is to help retain nurses in the field – nurses that we have nurtured and trained and desperately need at the bedside!

Ask Flo...

ASK FLO
This column is designed to answer questions about practice, education, administration or employment. Questions may be emailed to office@nhnurses.org with ***Ask Flo – NN*** *in the subject line, or sent via postal mail to our office address. All questions will be printed anonymously. But don't forget about our Mentor website as a resource: http://nhna.moodlehub.com*

Dear Flo,
We don't have a regular pharmacist at the facility I practice at, so drugs are delivered by an outside vendor three to four times a week. Sometimes I am too busy with residents and cannot stop what I am doing to sign for the delivery. It is OK to delegate this task to my very competent nursing assistant?
Signed, Busy LPN

Dear Busy,
No, you cannot delegate this task to a nursing assistant unless they are licensed by the state as a medication nursing assistant. Only RNs, LPNs or Medication LNAs can accept drug deliveries.
Flo

>>><<<

Dear Flo,
We recently had several nursing students on our unit. I got two students assigned to me and my 6 patients. I felt uneasy when they wanted to do a PEG-tube feeding without me watching them. Isn't my nursing license on the line if they mess up?
Concerned Nurse

Dear Concerned,
No one can practice under your nursing license but you. Speak to the student's faculty if you feel uncomfortable about a procedure or skill the student will perform. The academic program does have malpractice insurance coverage for the student and the faculty. Use the rights of delegation when you are precepting a nursing student, just like you would for another member of your team.
Flo

>>><<<

Dear Flo,
Every now and then, one of our patients has a bad case of diarrhea from c.diff. What a mess! And terrible for the patient! One of our new nurses told me that there is a new treatment being used for c.diff. but I didn't believe her! She said they are actually giving enema's to patients with normal people's feces! Whoa! That is hard to believe, and who mixes the enema? I think she is making this up!
Unbelieving Nurse

Dear Unbelieving:
Hold on to your enema bag! Your colleague is correct! Fecal or stool transplants (also known as FMT-fecal microbiota transplantation) have been used very successfully for a range of problems. The bacteria from a healthy donor's stool displaces the pathogenic organisms. In one study, 19 out of 20 patients with c.diff were cured after one treatment, with the last patient cured after a second "dose." The healthy bacteria were more effective than Vancomycin! And if an enema cannot be used, you can introduce the bacteria via NG tube or during a colonscopy. Donors are screened for parasites, with the lab preparing the 2 ounces of a liquid preparation of stool for transplant.
Flo

>>><<<

Dear Flo,
I just got a dream job, but it is for day-night rotation. Any tips on how to survive and still have a life? I don't want to gain back all the weight I just lost. Help!
PM RN

Dear PM RN,
One of the best strategies to adopt to the night shift is to carefully watch what you eat or drink. Caffeinated coffee is OK for the first 1-2 hours, but after that, switch to water. And a lot of water. They better hydrated you are, the better you will feel. Avoid all complex carbs, that mean no donuts, cakes, cookies or pizza. Bring fruits and veggies to munch on. Grazing at night is OK, put a big veggie platter out and snack away! Have your main meal between 2-4 AM, again avoiding carbs. A salad with chicken for protein is a winner. After you leave work, if you are going to bed when you get home, then have a bowl of cereal. The carbs and the milk will help you fall to sleep easier. Enjoy the night shifts!
Flo

NHNA Student of the Year – 2013

The NHNA Student of the Year award is given to a student nurse in an entry program who embodies all the finest qualities of nursing: **caring, professionalism, advocacy, leadership and involvement.**

Nominations were reviewed by NHNA's Commission on Nursing Practice – who were faced with a difficult choice. Ultimately they selected **Katie Laque of St. Anselm College** who accepted the award at the NHNA student conference. In addition to the award statue and complementary registration for the conference, the recipient is granted a one year membership in ANA and NHNA to be activated upon licensure.

Just a few accolades from many pages of Ms.Laque's nomination:

"Her sense of commitment to those in need is dedicated; her capacity to care seems intuitive... She was designed to be a nurturer and has a clear focus on supporting others." Some of her work as a student included: "participating in a nursing mission trip to Jamaica to provide care for severely disabled orphans; providing help and hope to a grandmother [who was] primary care provider of underprivileged brothers, terminally ill with muscular dystrophy, and offering home care services in the community." Her competence and academic excellence earned her a preceptorship in the ICU at Brigham & Women's Hospital. Katie was not only on the Dean's List every semester, but was also named Presidential Scholar at St. Anselm and is a member of the Sigma Theta Tau Nursing Honor Society. She is a member of the Student Nurses' Association and avid supporter of multiple community service projects - including providing transportation and support to chemotherapy patients. From a classmate: "She inspires service in others through her own compassion for a cause. She advocates for those she serves… she loves them and they love her… She is an angel in disguise to all those she encounters. Katie has touched more lives already than most people do in a lifetime."

CONGRATULATIONS, KATIE!

Special recognition and best wishes also go to the following 'runners up' who were highly recommended by faculty and peers from their schools:

Holly DeCarteret and **Kathleen Flaherty** from Rivier University
Kendra Newton – Plymouth State University
Nicole Annis – UNH and **Carissa Neddo** – Colby-Sawyer College

We have no doubt that each of these new graduates will be a credit to the nursing profession!

Katie Laque

Holly DeCarteret

Nicole Annis

Kendra Newton

Delivering Quality & Innovation in patient care

National Nurses Week May 6-12, 2013

As we have done for the past few years in honor of Nurses Week, NHNA again offered a special introductory dues rate for new members at employer facilities who allowed us to visit with ANA-NHNA information. We enjoyed getting to take part in some of the various celebrations offered.

Our visit to **Elliot Health System** was in conjunction with an educational symposium right before Nurses Week. **Southern NH Medical Center** invited us to attend their annual nurses' breakfast (with docs manning the omelet stations!) and education fair to encourage options for working on that next degree. *They also sponsored one-year memberships for the seven nurses who received special awards.* Similarly, the VA Medical Center provided a luncheon – served by 'management' – plus an awards ceremony.

Catholic Medical Center, Huggins Hospital and Valley Regional also offered education fair days where we set up with information on the benefits of professional membership. **DHMC Lebanon** and **Concord Hospital** incorporated our volunteer-staffed recruiting table into their Nurses Week activities. We thank each facility for the opportunity to visit and meet with staff members.

Southern New Hampshire Medical Center

VA Medical Center

Catholic Medical Center

Huggins Hospital

Pharmacologic Abuse: A National Epidemic

Dee-Dee Patrick, MS, RN, CARN, CLNC

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Scope of the problem

While most people take prescription medication responsibly, an estimated 48 million Americans (20% of the United States population) have taken these drugs for "nonmedical reasons" in their lifetimes. Nonmedical reasons include taking a prescription that was intended for someone else or taking a medication more frequently or at higher doses than it was prescribed. It also includes taking the drug for the mood-altering effect it provides, e.g., euphoria, calmness, self-confidence. Narcotic analgesics, opiods, are the most abused class of prescription drugs. They are also the preferred drug for diversion by health care professionals.

Americans consume 80% of the world's prescription opiates. Along with legitimate prescription usage, there has been an alarming rise in the abuse of illegally obtained controlled substances in the United States. Abuse of opiod analgesics has been described as the greatest epidemic in drug abuse since crack cocaine in the 1980s and 1990s. The consequences have, however, proved to be more fatal. Nearly 15,000 Americans died from unintended consequences of opiod analgesic use in 2008, according to the Center for Disease Control and Prevention (CDC). This accounted for more than 40% of all drug poisoning deaths that year. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of people seeking treatment for painkiller addiction jumped 400% from 1998 to 2008 (SAMHSA, 2009). Those individuals, however, remain in the minority and are the fortunate ones.

Cause of the problem

Why have prescription narcotics become so popular as the preferred mood-altering drug of abuse? The reasons are many. Pharmaceutical companies have aggressively marketed this class of drugs with retail pharmacies dispensing 257 million prescriptions in 2009, a 48% increase over the 174 million dispensed in 2000 (FDA). Some prescribers are enablers, even knowingly, by issuing prescriptions without a thorough assessment or face to face meeting. Pain, labeled the "fifth vital sign," was perceived as undertreated and health care providers were encouraged to not only assess but alleviate patients' complaints. According to the Drug Enforcement Administration, drug cartels began supplying Chicago street gangs with these pills to meet the demand. Lastly, these drugs are readily available from relatives and friends who eagerly share their prescriptions or have the drugs taken without their knowledge from their medicine cabinets. Americans falsely believe that prescription narcotics are a safe alternative to other illicit drugs.

Addressing the Problem

Opiod analgesics include these popular medications: Dilaudid®, Lortab®, OxyContin®, Fentanyl®, Percodan®, Tylox®, Norco®, Vicodin® and methadone. Some of these drugs are classified as Schedule II under the federal Controlled Substance Act of 1970. This classification rates them as having high potential for abuse and warns they may lead to severe physical dependence. Controls specific to Schedule II drugs include manufacturing quotas and prohibition of prescription refills. However, hydrocodone (Vicodin) and oxycodone (Percocet, Percodan), the most abused opiod analgesics according to DEA data, fall into the less restrictive Schedule III. This is because the opiod is mixed with acetaminophen or aspirin. Fear of being investigated by the DEA for their Schedule II opiod prescribing practices has encouraged a practice commonly referred to as the "chilling effect" in which prescribers favor ordering Schedule III controlled substances for their patients.

At the supply end, the United States Government has been mandating ways to keep pharmaceutical manufacturers accountable and responsible. The Federal Drug Administration Amendments Act of 2007 gave the FDA the authority to require a Risk Evaluation and Mitigation Strategy (REMS) from pharmaceutical manufacturers to ensure that the benefits of a drug outweigh its risks. A REMS goes beyond a drug's written prescribing information and is developed to address the unique risk/benefit profile of a drug. In July 2012, the FDA approved a REMS for extended-release (ER) and long-acting (LA) opioid medications.

In 2011, the Obama administration announced a five-year government wide initiative to cut prescription drug abuse by 15%. The Prescription Drug Abuse Prevention Plan includes action in four major areas to reduce prescription drug abuse:

- **Education**
- **Monitoring**
- **Proper Medication Disposal**
- **Enforcement**

Education—A crucial first step in tackling the problem of prescription drug abuse is to educate parents, youth, and patients about the dangers of abusing prescription drugs, while requiring prescribers to receive education on the appropriate and safe use, and proper storage and disposal of prescription drugs.

SAMHSA announced that it had selected the American Association of Addiction Psychiatrists (AAAP) to receive a three-year grant to develop the Prescriber's Clinical Support System. The purpose of this resource is to educate prescribers regarding the safe use of opiod analgesics in the treatment of chronic pain including training on how to recognize misuse, abuse, and addiction in those being treated with these medications.

Monitoring—Establish Prescription Drug Monitoring Programs (PDMPs) in every state to reduce "doctor shopping" and diversion, and enhance these programs to make sure they can share data across states and are utilized by healthcare providers prior to writing prescriptions. PDMPs serve as surveillance systems that document and record prescription or dispensing details focusing on both providers and patients.

There are currently 43 states, including Illinois, who have authorized PDMPs in place. These assist with early detection of opiod analgesic abuse by effectively tracking prescriptions for controlled substances. PDMPs are effective in holding both the prescriber and consumer of these medications accountable. Future focus will be on ensuring the individual state PDMPs are able to share data across states and are routinely accessed by healthcare providers.

Proper Medication Disposal—Develop convenient and environmentally responsible prescription drug disposal programs to help decrease the supply of unused prescription medications kept unsecured in the home. The Drug Enforcement Administration periodically holds "Take Back" programs with nearly 4,000 state and local law enforcement agencies collecting more than 774 tons of pills since its inception two years ago (DEA). Consumers, including health care facilities, are no longer encouraged to flush unused medications as this has been proven to contaminate our drinking water. If unable to take unused prescriptions to a local police station, consumers are advised to dispose of these medications in coffee grounds or used kitty litter prior to disposal in the garbage.

Enforcement—Provide federal, state and local law enforcement with the tools necessary to eliminate improper prescribing practices and stop pill mills. High Intensity drug trafficking areas (HIDTAs) have been identified as a means to reduce drug availability by creating intelligence-driven enforcement task forces aimed at coordinating drug trafficking control efforts. Rock Island County, located within northwest region of Illinois, has received this notoriety.

Addressing the Problem—Part II

Educating all healthcare providers about substance use disorders is paramount in addressing the appropriate and effective prescribing and administration of opiod analgesics. Addiction has been described as a disease of the brain. Current research postulates that developing the disease requires two variables:

1) a *genetic vulnerability*, whose variables may include the number of dopamine receptors in the brain. Those with too few receptors experience taking the drug as not particularly memorable, while those with too many dopamine receptors find it is outright unpleasant.

2) *repeated assaults to the spectrum of circuits* regulated by dopamine, involving motivation, expectation, memory and learning appear to fundamentally alter the brain's workings (NIDA).

The input between nature and nurture continues outside the confines of the human brain. Genetic factors account for about 50% of the likelihood that an individual will develop a substance use disorder. Environmental factors i.e., parental involvement, peer pressure, physical and sexual abuse, interact with the person's biology and affect the extent to which genetic factors exert their influence. The role of protective factors has been underestimated in the past. Parental monitoring, peer support, academic competence, self-control, and the value placed on professional licensure are all effective in keeping an individual from becoming addicted.

Addiction changes the brain circuitry, making it difficult to stop detrimental behaviors. In the non-addicted brain, control mechanisms constantly assess the value of stimuli and the appropriateness of the planned response, applying inhibitory control as needed. In the addicted brain, the control circuit becomes impaired or diminished due to drug abuse, losing much of its inhibitory power over the circuits that drive stimulus response. Changes in the dopamine circuits within the brain remain abnormally blunted, even after individuals have successfully detoxed and are clean and sober for an extended period of time. Experiences such as reading a good book, visiting with a close friend, seeing a beautiful sunset or eating chocolate cake elevate dopamine levels in normal subjects but have notable muted responses in former addicts. Only the drug of choice will send dopamine levels high enough to provide the desired response. This may explain the intense difficulty addicts have staying clean long term.

The areas of the brain that are affected by drug abuse all contain circuits that underlie feelings of reward, learning and memory, motivation and drive, and inhibitory control. All addictive substances send dopamine levels surging in the small central zone of the brain, the nucleus accumbens, which is also known as the main reward center. Central nervous system depressants such as alcohol and narcotics suppress the nerve cells that inhibit the release of dopamine. Opiods act on several areas of the brain and nervous system including blocking pain messages transmitted by the spinal cord, depressing brain stem function including decreasing the respiratory rate, and increasing feelings of pleasure by changing the limbic system which controls emotions.

If there is concern on the part of the prescriber that the patient may be at risk of abusing the opiod analgesic, he/she should request an opiod contract be signed by the patient. This agreement establishes an understanding that the patient will only receive opiods from that prescriber and obtain them at only one pharmacy. The patient may be asked to submit to random urine drug screening and told that if the medication is lost, it will not be replaced. Under this contract, reportedly stolen medication will only be replaced if the person provides a police report.

Potential signs of prescription drug abuse include:

- excessive mood swings
- increase or decrease in sleep
- poor decision making
- appearing to be "high"—unusually energetic or sedated
- taking higher doses than prescribed
- stealing, forging or selling prescriptions
- continually losing prescriptions, so more prescriptions must be written
- seeking prescriptions from more than one prescriber

Addiction in Nursing

Nurses' familiarity with medications and their mastery of administering them often results in nurses thinking that they can self-administer opiods without harmful consequences. They assume that they will know when they have crossed that fine line between using the drug as a means of coping and becoming psychologically and physically addicted to it. Nurses have directly observed the ability of pharmacological agents in diminishing pain and alleviating suffering in their patients. High levels of job stress related to higher patient acuity and increased work load in combination with having access to powerful narcotic medications also account for the heightened risk of nurses taking these drugs for nonmedical reasons. Many nurses are adult children of alcoholics with a legacy to rescue and help others. These factors in addition to a family history of substance use disorders and a previous or current recreational use of mood-altering substances tip the scales toward the nurse developing a

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substance use disorder. Vigilance and awareness are necessary roads to follow. Honest self-exploration of how we cope with stress and educating ourselves in how to identify potential signs of substance abuse in a colleague who may be struggling are necessary learning opportunities. We can and will continue to support each other as we flight this debilitating, seductive and potentially fatal disease.

References

Centers for Disease Control and Prevention/National Center for Health Statistics, National Vital Statistics System. Available at http://www.cdc.gov/nchs/data/databriefs/db81.htm

Department of Drug Enforcement. Available at http://www.deadiversion.usdoj.gov/drug_disposal/takeback/

National Institute on Drug Abuse. Available at http://www.drugabuse.gov/publications/science-addiction

Prescription Drug Abuse Prevention Plan. Available at http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf

SDI, Vector One: National. Years 2000-2009. Available at http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/AnestheticAndLifeSupportDrugsAdvisoryCommittee/UCM217510.pdf

Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

Nurse to Head CMS

Marilyn Tavenner

The US Senate confirmed Marilyn Tavenner, MHA, BSN, RN, as the permanent head of the Centers for Medicare and Medicaid Services (CMS). Tavenner, a former Intensive Care Unit (ICU) nurse, has served as chief executive officer of the Hospital Corporation of America (HCA) and was Virginia's secretary of Health and Human Resources under former Governor Tim Kaine. "Tavenner's nursing expertise, along with her public and private sector experience, will enable her to continue providing the Centers for Medicare and Medicaid Services (CMS) with the leadership needed to guide our health care system during this time of great change," stated ANA President Karen A. Daley, PhD, RN, FAAN. "CMS is an agency that touches the lives of all Americans, through the Medicare, Medicaid, and children's health insurance programs and other vital functions. With this confirmation vote, CMS is getting a superb leader who understands the need to expand patient access to high quality health care." Tavenner joined CMS in February 2010 and became acting administrator in December 2011. Tavenner's confirmation marks the first time CMS has had a permanent administrator since Mark McClellan resigned in 2006.

Nursing Fatigue: Complex Problem that Defies Easy Solutions

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Chris has more than 25 years experience in communications and public relations, including more than 20 in various health care positions. In 2005, Chris graduated from the University of Illinois at Chicago School of Public Health with a Master's in Public Health. In 2006, he started Chris Martin Public Relations, a solo PR consultancy focusing on health care. He is currently INA's Public Relations Consultant.

This winter brought more than record-breaking snows to the Midwest—it also brought further news of health care cuts at publicly funded hospitals in Cook County, for instance. The safety net health care system that represents the poor announced that one of its hospitals would stop accepting emergency patients and then followed that with news that 138 nurses in the system would be laid off.

These further attacks on nursing profession do not bode well for the remaining nurses who are left to care for those with intractable chronic diseases. Currently, nurses are experiencing alarming rates of fatigue, stress and job turnover.

To help address this and set national standards that hospitals and clinics could follow, the Institute of Medicine in 2004 established that nursing shifts should not exceed 12 hours in a 24 hour period or 60 hours during any seven-day period. However, 17 percent of nurses routinely exceeded that recommendation, according to research on nursing fatigue.

As more and more nurses and health care executive become aware of nursing fatigue, the central questions remain: how do you know when you're tired and what should you do to prevent it or address it?

Nursing researchers interviewed for this article all agree it is a complex, little understood and under studied problem and broad approaches are still in the research stages. Most approaches focus on the physical and emotional stresses that nurse's experience but according to one nurse-turned architect, nurse fatigue may be hard baked into the facilities nurses work.

Kerrie Cardon, RN, AIA, ACHA, worked as a floor nurse and went back to school to study architecture and has designed a lot of health care facilities and nursing units.

"The impact of a physical design and layout of a health care facility is an under-the-radar issue when it comes to nursing fatigue," Cardon said. As part of her research, Cardon did a job shadow study on a nurse and followed him for an eight-hour shift using a pedometer.

"During the eight-hour shift, he went six hours without sitting down and he missed his lunch and break," she said, repeating a familiar refrain common to most nurses.

Cardon has focused much of her work on how the physical environment affects nursing fatigue.

"The trend toward single patient rooms, which reduced hospital acquired infections, had unintended consequences," she said. Rather than seeing two patients at once, nurses now had to walk further to see the same number of patients, adding to the physical toll on their bodies over time.

"We've created better environments for patients and families but nurses have suffered," she said.

Cardon has identified four typical areas in hospitals that health care executives and nursing leaders should examine to determine if they are compounding the fatigue nurses experience:

1) **Charting.** Move to more mobile charting and charting at bedside is important but any mobile computing unit should be designed to be ergonomic and height adjustable while balancing the need for nurses to collaborate and discuss issues and patient care as a team.

2) **Supplies.** The trend is moving toward decentralized supply management following the corporate philosophy made popular by Toyota and its lean process. This has helped reduce walking distance to a distant and centralized supply location. Cardon recommended nursing units consider following this approach to bring supplies closer to where the nurses are working.

3) **Equipment.** Cardon believes hospitals under program the space in patient rooms. We should have one piece of lift equipment for every 2 to 4 rooms to help nurses prevent and reduce back injuries.

4) **Medications.** We need to move more medication into the patient rooms. Currently, nurses have to walk to the medication dispensing machine and wait their turn. These interruptions contribute to medical errors. "During the job shadow study, I saw first hand how often the nurse I was following was interrupted taking medications from room to patient room," she said. New approach uses bar codes but studies have found this is not perfect as there are often wireless dead zones in hospitals. This reaffirms the need to get medications back into the patient's room to reduce walking time and reliance on technology to ensure patients receive the right medication at the right time.

Linda Bell, MSN, RN, clinical practice specialist with American Association of Critical Care Nurses, has focused on more traditional nurse fatigue issues.

Bell said that nurses have been victim to the drive toward patient safety, hospital competitiveness and other health care industry factors.

"The focus on patient safety must concentrate on nursing care and as patients' acuity has gotten worse, this has exacerbated the burden on nurses to care for increasingly sicker patients," she said. When hospital stays were reduced from 10 days on average to two days for a heart attack, that created a faster pace and faster turnover, Bell said, and nurses sometimes have a hard time keeping up with this pace.

Bell said that nurses are often their own worst enemy too.

"When I started nursing, shifts were eight hours, five days a week, and that was typically enough for most nurses," she said. "The move toward three, 12 hour shifts has allowed nurses to pick up additional shifts at other hospitals. Younger nurses can handle this workload but as nurses get older their bodies aren't able to keep up with this demand."

Hospitals are more competitive than ever too. Bell stressed.

"Hospitals are businesses, and to run a good hospital you have to have good nurses," she said. But on a daily basis, when managers seek out nurses to work extra shifts or stay later, it's never difficult to get volunteers because nurses are committed to patients and don't like to leave loose ends."

Bell said there are no easy system-wide solutions to reducing nursing fatigue but recently she has focused on providing information to nurses about ways to become more aware of stress and fatigue and reduce it or prevent it from hampering patient safety.

Bell recommends four steps for nurses seeking ways to avoid fatigue:

1) **Self awareness.** You have to understand yourself and your body. If you are so tired you can't play a simple computer game, you are too tired to work so don't take that extra shift.

2) **Understand your own limitations.** You may not be tired now but if another four hours of work, you might be so tired you will be compromised.

3) **Sleep.** Americans have a huge sleep deficit and nurses are among the worst culprits of this. Bell couldn't stress the importance of sleep enough, especially for moms with young kids or those with spouses who have been laid off. Try to get 7 to 8 hours of sleep each night.

4) **Get help.** Look at resources you have, such as employee assistance programs, to help deal with personal problems that may be contributing to additional stress or fatigue.

Finally, more and more nurses are talking to their supervisors about fatigue. Gradually, managers are coming around to this trend and while Bell says managers aren't often trained to recognized fatigue, they are trained to look for compromised nurses or signs a nurse might be having trouble coping or managing her job.

"When a manager recognizes signs a nurse might be struggling, that manager is more likely to pull the nurse aside and provide support or help for the nurse to better cope with the problem or help her manage her time, for instance," Bell said. Fortunately, there are more resources for nurses today and help can be right around the corner.

The dynamic surrounding nursing fatigue is complex and multi factorial and while there is little research being conducted on the subject in the U.S, there is a compelling project underway in Europe and Mexico that a New York University researcher is participating in that may shed light on solutions that can be implemented in the United States.

Funded by the Seventh Framework Programme of the European Commission, the RN4CAST project aims at introducing innovative forecasting methods by addressing not only volumes, but quality of nursing staff and its effects on patient care as well, according to its website. The study comprises a consortium of research teams from Belgium, Finland, Germany, Greece, Ireland, Poland, Spain, Sweden, Switzerland, The Netherlands and the UK. Norway entered the project in a later phase and will serve as a reference country. The study focuses on medical and surgical care within general acute hospitals to create a clear picture of the relationship between nursing workforce planning and patient outcomes. Data was collected anonymously from nurses and patients in addition to hospital discharge records, to investigate how elements including nurse qualifications, demographics, workload, well-being and practice environment can affect productivity, patient safety and patient outcomes. Collectively, research in the 12 European countries encompasses up to 500 hospitals, 50,000 nurses, 12,000 patients and hospital discharge data from hundreds of thousands of patients. Researchers from three International Cooperating Partner Countries of the European Union are to collaborate in this largest ever nursing workforce study to be undertaken. They will provide a broader international perspective on the results of the study, which are expected mid 2011.

Allison Squires, BSN, MSN, PhD., assistant professor at New York University School of Nursing, is one of the researchers working on this project and said it has two main areas: examining traditional health care worker burnout and compassion fatigue.

Squires said the team she is working on is examining different European countries to determine if there are cultural or societal issues that contribute to nursing fatigue or help protect against it.

"Why," she asks, "Would nurse fatigue be a bigger problem among Mediterranean countries than northern European

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What else can nurses do to avoid fatigue?

Experts interviewed for this article all agree that avoid long-term fatigue, nurses must sometimes resist the gravitational pull the economy has that forces nurses to work extra shifts.

"Give yourself a rest," advised NYU's Squires. "Read a book, take up a hobby. It's just as important to be away from nursing to refresh as it is to be engaged in it."

Squires also believes Magnet status can help with long term fatigue issues. "Pursuing Magnet status is a rigorous, long term commitment and undertaking it can help change the way your hospital works," she said.

Several experts believe the over dependence on working 12 hour shifts contributes to fatigue. "Time and time again, research and anecdotal stories have shown that when a nurse works three days a week, she is more likely to pick up an extra shift or two at another hospital in her time off," said Bell. Over time, this had a degrading effect on a nurse's body and health.

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countries?" She theorized that culture and access to financial resources to treat patients may affect how nurses feel in their jobs.

Squires has done a lot of work with nurses in Mexico where the nurse to patient ratio is often as high as 1 to 20. And, when you add to that a system that is not well funded, nurses can get very frustrated.

"Many nurses in Mexico are caught in the middle between having to tell families they do not have a drug to treat their relative and hospital managers who they perceive should be doing more to provide these supplies," Hunter said.

Another area Squires and her colleagues are looking at is helping foreign-trained nurses adapt better to U.S. culture and medicine to ease their way into new jobs and a new environment.

"Foreign trained nurses comprise between 15 and 20 percent of the total nursing workforce and their issues can be different than U.S. born nurses," she said. Many foreign-trained nurses have to deal with the stress of a new home, new language and culture. Squires and her team have devised an intense English language program that not only helps with the basics but helps with clinical training to address known gaps in education, too.

As the nurse fatigue problem becomes better understood, more research will be conducted to attempt to find system solutions that work in a variety of health care settings. Until then, nurses are often left to their own devices to grapple with this problem.

Legislative Update - 2013

Lisah K. Carpenter, Chair,
NHNA Government Affairs Commission

While health care facilities, providers and nurses continue to be challenged on a daily basis by burgeoning regulation, limited resources and decreasing reimbursements, the NHNA Government Affairs Commission (GAC) continues its mission to identify legislative initiatives where nurses might have real impact, and to strategize the most effective way to utilize our collective voice. Each year, we begin by looking at the slate of bills that relate to health care, and our attention generally falls to practice-related issues and public health policy. This year marked a change in direction for us, as we tackled the enormous "gorilla in the corner" – the expansion of Medicaid in the state budget and trailer bills (HB 1 and 2).

The year began with a robust NHNA Town Hall in January. Hampered by the dearth of printed bills to review and discuss (a biennial problem), we soldiered on. We had approximately 200 participants at six sites, which allowed us to capture the voice of nursing from across the state. Introductory speakers included NHNA President, Judy Joy; NHNA lobbyist, Robert Dunn; and NH Representative, Vice-chair of the House HHS&EA Committee and nursing colleague, Laurie Harding.

The "short list" of bills presented by the GAC included:

- HB 217, an act imposing an extended term of imprisonment for assault against a health care provider (provider being broadly defined to include nurses and other health care workers);
- HB 403, an act establishing a commission to study death with dignity for persons suffering from a terminal condition;
- HB 573, relative to the use of cannabis for therapeutic purposes;
- HB 659, increasing the tobacco tax; and,
- SB 170, relative to advance directives pertaining to life-sustaining treatment.

The top priorities selected by the group in a virtual dead heat were: SB 170, which amended the definition of life-sustaining treatment to include medically administered nutrition and hydration, for purposes of advanced directives; and, HB 217, which extended the term of imprisonment for anyone convicted of an assault against a health care worker.

As an aside, I just want to say that in our review of the evaluations post-event, a number of suggestions were made that we plan to implement for next year. First, we plan to run the event a few weeks later, so that we will have more information on the bills. Second, we will implement a voting process that more evenly and fairly distributes the weight of each vote. Finally, we are looking at ways in which we can structure the event so that more time will be devoted to discussion of the priority initiatives. Our thanks to event participants for their comments and support.

In summary, SB 170 was adopted with amendments in both the House and Senate, but fortunately their differences were resolved and the Senate concurred (agreed to support) with the House version. This amendment to the advanced directives statute repeals the language that required a person to expressly state directions specific to artificial nutrition and hydration – a section that often led to confusion at the bedside. NHNA supported this change and congratulates the efforts of the advanced directives alliance, ably guided by Shawn LaFrance at the Foundation for Healthy Communities.

Regrettably, HB 217 faced stiffer opposition, and was retained in Committee. Under some circumstances, this might be viewed as a more politically acceptable way to kill a bill; in this case, however, legitimate concerns were raised during the hearing process, and the Committee will use the additional time to investigate, discuss and further debate the issues. **For those who are interested in the fate of HB 217, it is a good idea to pay attention to the meetings that are scheduled between now and November. The public is welcome and often invited to comment during these sessions.** The best way to keep tabs is to check the HB 217 docket periodically. Go to www.nh.gov> Legislative Branch> Quick Bill Search, and plug in HB217 (no spaces). From there you can click on the "docket" tab and view the scheduled activity.

With little opposition to SB 170, and HB 217 being set aside early on in the session, the GAC decided to turn its attention to the heated debate swirling around the expansion of Medicaid. Accepting federal dollars to increase the number of people who would be covered by Medicaid and thereby have more ready access to primary care was a message we felt would resonate loudly within the nursing community. The House version of the budget included Medicaid Expansion, but we knew that leadership in the Senate had concerns. We began with an Op Ed piece that was picked up by the Nashua Telegraph, Keene Sentinel, Union Leader, Eagle Times, Laconia Citizen, Foster's Daily Democrat, Portsmouth Herald and the NH Business Review. It was very heartening to receive this confirmation that the voice of nurses remains trusted and credible.

In the weeks leading up to this writing, NHNA has posted a number of legislative 'ACTion' Alerts to the membership, asking for targeted telephone calls to key Senators whom we felt might swing their votes in support the expansion. Although we only needed two votes, the full Senate voted to exclude Medicaid expansion from its version of the budget. At press time for Nursing News we are heading into the critical Committee of Conference, where deals are struck and anything can happen, NHNA will continue to monitor closely and engage as appropriate. By the time you read this, the deed will be done. I remain hopeful for a good outcome.

Once again, the NHNA GAC hosted two Health Policy Days this spring – always a popular event for students – each day saw the maximum of eighty registrants. Health Policy Day is designed to introduce nursing students to policy development and state-level advocacy. It is our goal that students leave the State House feeling empowered and enthusiastic. For reasons too numerous to elaborate upon here, the GAC is looking to overhaul this event. Please stay tuned!

I would like to close by thanking each nurse who made the commitment this year to stay informed about policy matters, and who reached out to Legislators with letters and phone calls. Your effort does matter, even when the vote does not always go our way. I would also like to extend a big welcome to the newest members to the GAC – the "old guard" is thrilled to have the collective wisdom, experience and enthusiasm of these nurses. Be well, be safe – see you in 2014!

The 'Skinny' on Soda Pop: Nurses Must Be on the Front Lines

by Ruth Fogg, PhD, Lydia Beal, BA, Charlene Bartlett, and Elise Levesque

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From the mineral waters of natural springs, to the effervescence of cool seltzer water, to the sweet bite of root beer, humans have been in love with carbonated water and soft drinks since the late 1700s. Before the commercial sale of Coca Cola® and Pepsi®, the consumption of natural or artificial mineral waters was considered a healthy practice. These mineral waters were sold in drug stores, and became more popular after pharmacists started adding medicinal and other flavorful herbs to the otherwise unflavored beverage. In time, drug store soda fountains became the backbone of Main Street America, and many people looking back on the 1940s and 1950s affectionately recall the experience of sipping a cherry cola or root beer float at the drug store counter.

Once considered a treat and advertised as a passport to refreshment, soda is now consumed worldwide on a daily basis. In 1949, milk consumption in the U.S. was four times greater than soft drink consumption. Fifty years later, soft drink consumption more than doubled over milk consumption by a ratio of 2.3:1 (West et al., 2006). The consequence of mass marketing combined with succumbing to one's "sweet tooth" by drinking soda has contributed to the U.S. becoming a nation of overweight and obese people (Ebelling et al., 2012). Over 30 percent of the population is classified as overweight with a body mass index (BMI) of between 25 and 30, and another 35 percent of the adult population is considered obese with a BMI greater than 30 (Centers for Disease Control and Prevention, 2012).

As soda intake increases, an almost concomitant decrease in milk consumption occurs. Milk contains 70 percent of the calcium in food consumed by Americans (Weaver & Heaney, 2006). Thus, adults and children who rely on soda as a regular part of their daily diet are often deprived of sufficient amounts of calcium, an essential bone-building mineral. In fact, the decrease in calcium intake over the past 60 years and the increase of soft drink consumption is linked to two observed health problems: an increase in dental caries and a decrease in bone density.

Soft drinks come in many flavors, but they all have essentially the same basic ingredients: carbonated water, a sweetener such as sugar or aspartame, and an acid such as phosphoric or citric acid to balance the sweet taste, flavorings, and preservatives. Depending on the type of drink, each 12-ounce serving contains 39 grams (e.g., Coke®) to 50 grams (e.g., orange soda) of sugar, which is 100 percent of the recommended daily amount of carbohydrates (i.e., 40 grams). One teaspoon of sugar is 4.2 grams and 15 calories. A 12-ounce serving of orange soda contains nearly 13 teaspoons of sugar, enough to make a person queasy if it were not for the citric acid or phosphoric acid, which masks the sweetness. With more sugar going into the body than the body can process, the liver quickly and very efficiently starts converting the excess sugar to fat for storage as it were. If a person consumes two 12-ounce cans of soda per day in addition to what is normally ingested by way of food and other beverages, then just from the soda alone, he or she will gain one pound of additional weight each week.

Now let's look at the acid in soda. Phosphoric acid is an inexpensive acid used to remove mineral deposits and rust, and it also provides the "bite" or tangy taste of many carbonated beverages such as Coca Cola®. Phosphoric acid is more acidic than citric acid, putting sodas at 2.5 on the pH scale (water is 7), more acidic than lemon juice or vinegar. We do not notice the acidity because of the effect of the sugar, which obscures the acidity. However, acid etches away at our teeth and bones. According to dentist Kaplowitz (2011), "Soda pop has emerged as one of the most significant dietary sources of acid capable of producing demineralization of (tooth) enamel" (p. 15).

Consumers may think that the artificial, non-saccharide sweeteners in diet soft drinks are a way to have a sweet treat without gaining any additional calories. This assumption is incorrect. According to Batmanghelidj (2003), the production of body enzymes are prompted by the taste buds. Sweetness normally translates to the entry of natural energizing glucose into the body. Within seconds, the pancreas starts producing insulin to allow the body cells to absorb the glucose. But since there is no glucose coming into the body, just an artificial sweetener, the "fooled" body goes into food anxiety, which in turn, increases the appetite (Batmanghelidj, 2003).

Moreover, since the late 1980s, the safety of aspartame, 200 times sweeter than sugar, has been hotly debated. Through the process of digestion, aspartame breaks down into phenlylalanine, an amino acid necessary for protein synthesis. However, some studies have linked increased levels of phenlylalanine to neurotoxic health effects, including seizures and brain tumors (Maher & Wurtman, 1987). Additionally, aspartame breaks down in the body into several chemicals, one of which is methanol or wood alcohol. Methanol is excreted very slowly by the kidneys via urine. Increased levels of methanol from drinking diet soda can cause vision disorders, headache, tinnitus, dizziness, nausea, gastric and behavioral disturbances, and numbness (Ekong, 2009). Methanol, a known carcinogen, is further metabolized by the body into formaldehyde (Speit & Merk, 2001), and long-term use of aspartame has suspected links to cancer.

A craving for soda is frequently established in childhood, and once developed, the habit persists through adolescence and adulthood. Furthermore, soft drinks, which are consumed as much for taste as to quench thirst, are readily available, inexpensive, and provide a quick "pick-me-up." An unsuspecting public is largely unaware of the negative health issues associated with the large quantity of sugar and acid in soda. Diet sodas, with their appetite-stimulating quality and neurological and cancer-causing potential, are no better. However, because of their knowledge of health and their skill in health teaching, nurses are in a prime position to educate the public about the harmful affects of soda, and to encourage drinking alternative beverages that contribute to health, while simultaneously satisfying one's thirst and desire for taste. Furthermore, nurses can and should be at the forefront of preventing the rising rates of obesity and its sequelae. Suggestions for beverages in place of soda can include drinking water, which, in most places in the U.S., is safe to drink from the tap. A slice or two of fruit (e.g., citrus fruit or strawberries) added to a glass of water can provide a hint of natural flavor. Herbal teas and green tea are also inexpensive and are readily available alternatives. Adapting one's taste buds to beverages that lack the accustomed sweetness of soft drinks is a process. But the effort to shift towards healthier, zero or low-calorie drinks is well worth the effort when improved health and decreased risks for chronic disease are considered.

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References

Batmanghelidj, F. (2003). *You're not sick, you're thirsty! Water for health, for healing, for life.* New York: Warner Books.

Centers for Disease Control and Prevention (2012). *Overweight and obesity.* Retrieved from http://www.cdc.gov/obesity/index.html

Ekong, M. B. (2009). Aspartame: Sweet or bitter. *Internet Journal of Health, 9*(1).

Kaplowitz, G. (2011). Continuing education course: An update on the dangers of soda pop. *The Dental Hygienist, 80*(4), 14-28. Available from http://www.colgateprofessional.com/LeadershipUS/ProfessionalEducation/Articles/Resources/pdf/profed_art_soda-pop.pdf

Ebbeling, C. B., Feldman, H. A., Chomitz, V. R., Antonelli, T, A., Gortmaker, S. L., Osganian, S. K., & Ludwig, D. (2012). A randomized trial of sugar-sweetened beverages and adolescent body weight. *New England Journal of Medicine.* doi: 10.1056/NEJMoa1203388 Retrieved from: http://www.nejm.org/doi/pdf/10.1056/NEJMoa1203388

Maher, T. J., Wurtman, R. J. (1987). Possible neurological effects of aspartame, a widely used food additive. *Environmental Health Perspectives, 75*, 53-57.

Speit, G., & Merk, O. (2001). Evaluation of mutagenic effects of formaldehyde *in vitro*: detection of crosslinks and mutations in mouse lymphoma cells. *Mutagenisi, 17*(3), 183-187.

Weaver, C.M., R.P. Heaney. (2006). Food sources, supplements and bioavailability. *Calcium in Human Health*. C.M. Weaver and R.P. Heaney (Eds). Totowa, NJ: Humana Press, p. 129. West, D., Bursac, Z., Quimby, D., Prewitt, E., Spatz, T., Nash, C., Mays, G., Eddings, K. (2006). Self-reported sugar-sweetened beverage intake among college students. *OBESITY, 14*(10), 1825-1831.

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