Careful Nursing by Catherine McAuley is the Professional Practice Model for Nursing at Saint Clare’s Health System. Careful Nursing has four concepts: therapeutic milieu, practice competence and excellence, nursing management and influence in health systems, and professional authority. This issue of the Careful Nursing News will focus on GREAT TENDERNESS IN ALL THINGS which is one of the eight dimensions of the Practice Competence and Excellence Concept. So read more about Careful Nursing!

WANTED ROVING REPORTERS!

The Careful Nursing News is published every other month, and we are looking for YOU to be a Roving Reporter. If you have a “nose for news,” send your article or article ideas to Sue Weaver. The vision of this newsletter is to share new evidenced-based practice information along with nursing news at Saint Clare’s.

Many nurses read the July/August issue of Careful Nursing News and were entered to win the book Illuminating Florence: finding nightingale’s legacy in your practice by Alex Atwell.

Congratulations to Christine Smith, MSN, RN, CLNC, Staff Nurse, OR who is the winner of the book. SO READ THE Careful Nursing News CAREFULLY, just like the members of Nurse Practice Council, because. YOU may be the next winner.

Keep calm and get your flu shot!
ARE WE SMARTER THAN A FIFTH GRADER?

In looking at the topic for this month, “Great Tenderness in all Things”, I knew that I had to “put my two cents in” as this is the most important quality I believe every nurse must have. Any one of us can complete the formal classwork required, obtain advanced degrees, add letters after our names that proclaim us to be “Super Nurses”… however, will you have “formal training” in compassion? In “how to care”? As we walk through the halls of our workplaces, those that will teach us compassion, humility, and resilience, will be our patients! For each simple act of kindness you bestow, you will see the gratitude in their eyes when they cannot speak, or hear the thanks of their loved ones who sit quietly at bedside, or the squeeze of your hand when you bestow some small measure of comfort. Perhaps to you, this is “all in a day’s work”… to your patient, it can mean everything! The difference between a miserable patient care experience and an exceptional one!

I asked if, as a nurse, received training in how to be compassionate? Imagine this- Teachers of K-5th graders, have access to “The Popcorn Park Puppets” which is a curriculum based on “Six Pillars of Character” – one of which is shown below:

HOW TO BE A CARING PERSON

Treat people with kindness and generosity.
Help people in need.
Be sensitive to people’s feelings.
Never be mean or hurtful.
Think about how your actions will affect others.
Always remember - we become caring people by doing caring things!

I imagine that if nurses ascribe to this simple six step approach to colleagues and patients in their care, we would be well on our way to creating the highest quality of care for everyone!! After all, I think we can brag that “We are as smart as these Fifth Graders”, don’t you?

Susanne Graham, MA, RN-BC, S.L. (Still Learning)
Administrative Director, Behavioral Health

THE THREE D’S: DELIRIUM, DEMENTIA, AND DEPRESSION

My 83 year-old father was taking his daily walk in the neighborhood when he fell and fractured his nose. Because of his other medical problems, he was admitted to the hospital. When I finally saw him he was a totally different person: confused, agitated, and trying to remove the nasal packing. Could this be delirium? The residents quickly ordered medications to calm my father down, with no success. However with my mother’s patience and non-pharmacological interventions, such as reorienting, talking about family activities, assisting him with eating, and helping him out of bed and ambulating, my father was able to return home.

At Saint Clare’s, we have spent the last year trying to increase awareness on the topics of Dementia and Delirium. It has been the topic of many discussions during Fall Prevention Rounds, at Nurse Practice Council and in multiple other meetings in our efforts to determine how to best screen, assess, educate and most importantly, care for our older patients who suffer from these conditions. To make this more complicated, it is equally important to also recognize the clinical features of depression, because in older adults, depression is often diagnosed as dementia (Edwards, 2003).

The theme of this newsletter, great tenderness in all things, exemplifies how we need to care for these particular populations. It isn’t just about recognizing signs and symptoms and having the clinical know-how on the manner in which we treat these patients. There must be the emotional component as described by Meehan (2012): sensitive, loving, kind, compassionate, gentle and above all, patient!

One of the most difficult things in caring for patients with Dementia, Delirium and/or Depression is the wisdom to know and understand the difference. They are so closely related that the distinction is often lost in the subtleties of the presentation.

The following link outlines a comparison of Dementia, Delirium and Depression: http://www.dartmouth-hitchcock.org/dhmc-internet-upload/file_collection/3ds_features.pdf

Historically, confusion was assigned to the elderly as typical and age-related and therefore quickly dismissed. Up to a third of patients 70 years and older, experience delirium. There is often a higher rate in the ICU and for patients who have undergone surgery. It can extend hospital stays and contribute to poor outcomes if left unrecognized and/or untreated (Collier, 2012). Elderly patients with a diagnosis of dementia are more susceptible and at risk to develop delirium when hospitalized so it is important to have baseline information and a history of the patient.

This was the experience I had when my mom was admitted to the ICU for need of a pacemaker. At 79 years old, my mom had already progressed into the advanced dementia stage. At this time, she was hospitalized due to long periods of asystole, presumably from too many Black Box Warning medications used to temper the behavioral challenges she presented over the years from the dementia. Within hours, I saw the delirium set in: fear and visual hallucinations. These were the differences that were important to note as any other symptom could have equally been assigned to the dementia.

When we hear the term delirium, most visualize patients, like our par-
ents, acutely disoriented, agitated and possibly hallucinating. It is important to understand the fluctuations of moods that can occur with the patient who develops delirium as often a hypoactive delirium can easily be confused with depression. There are key factors associated with delirium which need to be considered when caring for your patients. Is there an acute onset and fluctuating course of mental status and behaviors? Is there notable inattention? Is the patient’s thinking presented as disorganized and/or illogical? Has there been an alteration in the level of consciousness?

When caring for patients with delirium or dementia, key successes can also be achieved through non-pharmacologic interventions. These include cognitive activities and orientation, discontinuing restraints and/or foley catheters, minimizing or decreasing loud alarms or environmental noises, providing music, dimming the lights and mobilizing patients early during their hospital stay (Thomas, Smith, Forrester, Heider, Jadotte, & Holly, 2014). The use of medications may be the initial response from clinicians, especially when patients are presenting with behavioral challenges. Unfortunately, elderly patients often have paradoxical reactions to some medications which only perpetuate the challenging behaviors.

Educating the nursing staff about differentiating delirium, dementia, and depression is also an important component to successful management of these patients. The American Nurses Association has just announced the formation of a delirium task force and the first action of this task force is to survey RNs about their knowledge regarding delirium. Please join us on our education journey learning more about delirium, dementia, and depression.

References


Donna Scott, RNC, MPA
Accreditation & Patient Safety Coordinator

Editor

Nurses – The Challenges with Using Social Media

According to the ANA (2014), the definition of social media is: the online and mobile accessible services that enable individuals to connect, collaborate, and share with others in real time.

There are numerous social media sites available for nurses to connect with colleagues, share information about best practices, and advance healthcare. Social media is associated with a nurse’s professional development across four domains of nursing: clinical practice, academics, administration, and research (ANA, 2014). Social media allows nurses to exchange information and ideas with healthcare colleagues across organizations and geographic borders. Social media provides timely access to credible health information which is essential to control the transmission of outbreaks (H1N1 and Ebola) and maintain public health.

The use of social media is not without risk. Whenever nurses use social media, they need to be cognizant of their professional, ethical and legal obligations to maintain patient privacy and confidentiality at all times. Nurses must understand that they can be held accountable to professional standards for their private actions. Nurses must always be mindful of employer policies; relevant state and federal laws; and professional standards regarding patient privacy and confidentiality. The most common violation that nurses commit is a breach of patient privacy (HIPAA)/confidentiality, intentional or unintentional, or the failure to report a breach of privacy. Violation of patient privacy can result in termination, suspension, loss of nursing license and civil or criminal penalties. A nurse could face personal liability and be sued for defamation, invasion of privacy, or harassment due to unprofessional or unethical conduct, breach of confidentiality and mismanagement of patient records. When using social media, nurses must NOT:

1. use patient’s names or information that may lead to identification of a patient;
2. share any information gathered through the nurse-patient relationship;
3. discuss patients in a negative manner, even if the patient is not identifiable;
4. take photos or videos on mobile devices; or
5. accept a contact request from a current or former patient as it blurs and damages the therapeutic relationship.

Limiting access to postings through privacy settings is not sufficient to ensure your privacy. Lastly, social media must not be used to bully or harass colleagues or make disparaging comments about their employer or supervisor. Nurses must hold themselves to the highest professional, moral, ethical and legal standards during all methods of communication.

References:

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Shift Supervisor, Resource Team

PATHWAY TO EXCELLENCE®: THE WORK ENVIRONMENT IS SAFE AND HEALTHY

The Pathway to Excellence designation is granted based on the confirmed presence and integration of the 12 Pathway to Excellence Practice Standards. In each issue of the newsletter, a different practice standard will be reviewed. For Practice Standard 2: The Work Environment is Safe and Healthy - Direct care nurses actively participate on safety committees and in product evaluations.

According to Occupational Safety and Health Administration (OSHA), there are 6.8 work related injuries and illnesses for every 100 full time hospital employees. This dubious distinction has hospitals leading other industries in OSHA recorded injury occurrence. In 2012, the health workers rate for injuries resulting from workplace violence and illnesses involving days away from work was 15.1 per 10,000, compared to only 4.0 for private industry. Rates for musculoskeletal injuries resulting from patient handling and movement were 76 per 10,000 fulltime workers compared to other industries, 38 per 10,000. Centers for Disease Control and Prevention (CDC), stated that Health Care Workers have between 600,000 to 800,000 needle sticks or other percutaneous injuries annually which exposes workers to bloodborne pathogens that can cause infections such as HBV, HCV and HIV.

Saint Clare’s Health System is pro-active in creating collaborative process improvement plans to assess workplace hazards for employee injury prevention. Employee Health in collaboration with Infection Control, Nursing, Risk Management and other Ancillary Departments, have programs in place to reduce work related injuries and illnesses among its employees. For wellness and disease prevention, initiatives include annual mandatory flu vaccination, TB screening and respirator fit testing. Employees are encouraged to take charge of their health through our wellness program.

Saint Clare’s employee safety initiatives include reduction of work related injuries related to blood borne pathogen exposure, workplace violence, falls, and patient handling and movement. Reduction of work related injuries pertaining to needlestick and blood borne pathogen from Jan-June 2015 was down 50% from the previous year.

Workplace violence is a not only a nationwide issue but also a concern for Saint Clare’s. At the September Nurse Executive Council meeting, the new American Nurses Association position statement, Incivility, Bullying and Workplace Violence, was reviewed and discussed. An outcome of this discussion was to revitalize Saint Clare’s Violence Committee with direct care staff such as Laura Gundlach, RN from the Emergency Department. This corresponds with the Pathway to Excellence Practice Standard 2: The Work Environment is Safe and Healthy, that direct care nurses should be actively participate on safety committees. If you would like to join Saint Clare’s Violence Committee please contact Charlie Kerr at 973-625-6548 or me at ElisaGreen@saintclares.org or 973-989-3222. Also please take time to review the ANA position statement, Incivility, Bullying and Workplace Violence, which identified actions that nurses and employers should take to prevent workplace violence.

For other safety initiatives we still have areas for improvements which can be effected by management and leadership support, employee participation, identifying and assessing safety hazards promptly, prevention and control, education and training, and lastly program evaluation and
the ideological desire for further improvement. This is a challenge that we as employees and leaders should embrace as a system that fosters the culture of safety in the workplace.

Reference:

http://www.cdc.gov/niosh/topics/bbp/
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=...

Elisa P. Green, RN, MSN, APN-BC
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MUST WATCH

Nurses: Their Vital Role in Transforming Healthcare
https://www.discovernursing.com/nursesvital

“Nurses: Their Vital Role in Transforming Healthcare,” narrated by Joan Lunden, is an inspiring half-hour documentary that explores the impact of nurses on our nation’s health care system in our community, on patients and their families, and of course, on the nurses themselves. Nurses in Montana, Vermont and Washington show the important role they have on both the front lines of health care, as well as the backbone of patient treatment. “The future of nursing is headed into the community” states Susan Hassmiller, PhD, RN, FAAN, “It is really where patients want to be cared for”.

Professionalism

It’s not the job you do. It’s how you do the job.
Anonymous

JAN’S NURSING NOTES

The nurses at Saint Clare’s truly treat our patients with compassion, gentleness, patience and loving kindness, which is the theme for this newsletter. When I started at Saint Clare’s, many years ago, that was how I treated the patients I took care of in the Emergency Department.

As your Chief Nursing Officer, I am and have always been proud of Saint Clare’s and the nursing staff. I started my nursing career at Overlook Hospital and Riverside Hospital in Boonton. Then I came to Saint Clare’s working evening shift in the Emergency Department, when my children were young. Through the years I held positions as Emergency Department Manager, Director, and then most recently Executive Director of Clinical Operations.

This is an exciting time at Saint Clare’s as we have joined Prime Health care Services. This month we had a very successful Joint Commission (TJC) Disease specific Stroke survey and we are expecting TJC Disease specific survey for Hip/Knee. Additionally preparations are beginning for our TJC triennial survey next summer.


These are such important issues. As an ER nurse, I am familiar with the emotional distress and injury that can occur with workplace violence. I would encourage you to read the ANA position statement which includes recommendations for nurses regarding the importance of using situational awareness to identify the potential for violence before it occurs. At the September Nurse Executive Council we discussed workplace violence and have decided to revitalize Saint Clare’s Violence Committee and to examine the recommendation for prevention of workplace violence at Saint Clare’s.

My goal is to continue to be a supportive and available nurse leader. I look forward to talking with you.

Take care,

Jan Bednar, BSN, MS, RN, CEN, NEA-BC
Chief Nursing Officer
Saint Clare’s Health System Nursing has adopted Careful Nursing as the Professional Practice Model for nursing practice. Careful Nursing has three philosophical assumptions and four concepts: therapeutic milieu, practice competence and excellence, nursing management and influence in health systems, and professional authority. This issue of the Careful Nursing News will focus on GREAT TENDERNESS IN ALL THINGS which is one of the eight dimensions of the Practice Competence and Excellence Concept. Meehan (2012) explains this theme of the newsletter as, “An attitude of sensitivity, loving kindness, compassion, gentleness and patience in attending to all experiences and needs of patients.” (p. 2911).

The Careful Nursing professional practice model has FOUR Nursing Concepts (Dimensions) and 19 accompanying Key Practice (Concepts) Dimensions.

I. Therapeutic Milieu
   a. Caritas
   b. Inherent human dignity
   c. Nurses’ care for selves and one another
   d. Intellectual engagement
   e. Contagious Calmness
   f. Safe and restorative physical environment

II. Practice Competence and Excellence
   a. Great tenderness in all things
   b. ‘Perfect’ skill fostering safety and comfort
   c. Watching and assessment
   d. Clinical reasoning and decision-making
   e. Patient engagement in self-care
   f. Diagnoses, outcomes, interventions
   g. Family, friends, community supportive participation in care
   h. Health education

III. Management of Practice and Influence in Health System
   a. Support of nursing practice
   b. Trustworthy collaboration
   c. Participative-authoritative management

IV. Professional Authority
   a. Professional self-confidence
   b. Professional Visibility


Recall also that our philosophy tells us that as human persons, we and our patients are unitary beings with two distinguishable realities, an outward bio-physical reality of body and senses and an inward psycho-spiritual reality of mind, spirit and communion with Infinite Transcendent Reality. As unitary beings these realities are always present to us, albeit at different levels of awareness. We experience them simultaneously although we tend to think of them separately.

As we considered the therapeutic milieu dimension concepts over the past several months, we were aware that they are mainly concerned with the inward, psycho-spiritual reality of our life and the life of patients.
Very importantly, these concepts concerned the inner essence of our relationships with patients.

In turning to the practice competence and excellence dimension concepts, we will see that they are mainly focused on the outward life of body and senses, the bio-physical reality of our life and the life of patients. They are often viewed as what we do as nurses. This is understandable because the outward life is mainly objective, observable, and most of its characteristics can be measured.

Most of the practice competence and excellence concepts are vital to protecting patients from harm and in acute care settings some are frequently critical to patient survival. In this sense this dimension is the most important in Careful Nursing. If we do not practice the therapeutic milieu concepts very well vulnerable patients can feel lonely, disrespected and deeply hurt. If we do not practice most of the practice competence and excellence concepts very well, the very life of patients can be at serious risk.

Most practice competence and excellence concepts are immediately recognizable as steps of the nursing process. In Careful Nursing they are specified and emphasized in particular ways. We implement them at least with competence and always with an eye to achieving excellence.

**Why the term practice competence and excellence was chosen**

Analysis of the historical documents from which Careful Nursing was constructed revealed that most content described the nurses’ direct care of sick and vulnerable people in hospitals and communities. The data strongly suggested competence as the best descriptor of their clinical practice because they assessed patients’ needs and their personal, social and economic situations comprehensively; were organized, innovative, clear and confident about the care to be provided; were invariably calm, kind and patient in manner; were adroit at managing the community and organizational circumstances in which they were practicing; and were able to adjust quickly and appropriately to sudden changes and emergency situations. They were widely respected for their nursing practice ability, even by people who were very opposed to their cultural background and spiritual beliefs.

The data also suggested that the nurses’ ultimate practice aspiration was excellence. While they viewed excellence, in part, as using their knowledge and ingenuity to create the very best overall circumstances possible to promote patient safety and healing, ultimately excellence included fostering and recognizing moments of transcendent love, peace and joy that could emerge for patients in the flow of human healing relationships.

A brief review of the literature on competence and excellence will help set these concepts in the contemporary context.

**Competence**

Although competence has been analyzed extensively in philosophical and professional literature over recent decades and although it appears everywhere in the nursing literature, its meaning remains ambiguous. It continues to lack consistent definition, including among health professionals (Fernandez et al., 2012). Searching for the meaning of competence in nursing has been likened to entering a “bottomless pit” (Watson et al., 2002, p. 428).

Definitions of competence in dictionaries indicate that it signifies being capable of doing what one is expected or licensed to do. For example, our registration as professional nurses attests to our practice competence and signifies to the public that we know what we are doing. At the same time, and less reassuring, being competent can imply being only adequate or passable in meeting performance responsibilities.

Historically, competence was thought of in intellectual terms, for example knowing a body of knowledge well and having the ability to think critically. But this view became almost completely displaced by behaviorist theories of competence concerned with performance of functional skills, often called competencies, and theories of cognitive competence. Such theories, applied particularly to clinical competence, came to be contrasted with intellectual competence and preferred in practice settings.

Behavioral and cognitive competencies are obviously very important, the bedrock of clinical competence in nursing. But sole emphasis on them has been widely criticized because they exclude social and other contextual influences on competence and marginalize the principles and values fundamental to the practice of public service professions (Hyland, 1997). Thus, efforts have been made to broaden the meaning of competence. It is now increasingly being considered a holistic concept, for example, as it is summarized by Le Deist and Winterton (2005) to include the following aspects:

- functional: skills specific to a profession which can be demonstrated
- cognitive: knowledge which includes informal, tacit knowing derived from experience
- personal: characteristics known to be desirable in the practice of a professional group
- ethical: appropriate personal and professional values upon which to make sound judgements in varying practice situations
- meta-competence: being able to cope with uncertainty and engage in learning and reflection

A holistic understanding of competence is evident in most nursing codes of professional practice and scope of practice documents. In fact, nursing’s adoption of a holistic definition of competence is in keeping with the word’s original Latin meaning: com, meaning to come together jointly or simultaneously and petere meaning to seek or desire. Competence originally signified bringing different factors or persons together in seeking what was required or desired (Partridge, 1958). Interestingly, through its Latin source competence is closely related to the idea of competition, which implies that it can also suggest striving for excellence.

**Excellence**

Excellence immediately signifies going beyond competence. In the well-known work of Benner (2000), excellence is being an expert practitioner. For Benner, what is necessary for excellence is the ability to build on
theoretical knowledge by moving beyond it to understand and act on its meaning in different relational and contextual situations, always with attentiveness, kindness and compassion.

In reaching toward excellence we can take some cues from our philosophers, Aquinas and Aristotle. In previous articles on health as human flourishing (CNN 5(2), 2014, pp. 6-8) and (CNN 5(3), 2014, pp. 5-9) we discussed the virtue theories of Aquinas and Aristotle. Both philosophers define virtues as habits of thinking and acting in excellent ways that help us to live a flourishing life. They can help us flourish in our professional life; to practice with excellence.

Recall that Aquinas’s and Aristotle’s ideas about virtues relate to two central aspects of our practice, thinking (intelligence and insight, scientific knowledge, prudence, and wisdom, etc.) and doing (courage, generosity, good temper, truthfulness, and justice, etc.). A third aspect of our practice, the spiritual in nursing, is addressed by Aquinas in his three additional virtues of faith, hope and love. Earlier this year (CNN 6 (1), 2015, pp. 9-15), we considered how the virtues of friendliness, courage, gentleness and wittiness can foster care for ourselves and one another, which we can think of as excellence in professional relationships.

In reaching for excellence we can also draw on the values evident in our professional codes. Values are similar to virtues in some ways and can be thought of as virtues. For example, we can think of respect and personal integrity as habits of thinking and acting that help us attain excellence. Overall, we might particularly keep in mind the virtue of prudence or practical wisdom, which enables us to act according to Aristotle’s right rule. That is, to choose to act at the right time, with the right motive, with the right people, in the right way.

A competence-excellence continuum

Overall, the literature suggests that competence and excellence form a kaleidoscopic continuum intended to move from competence as satisfactory performance of functional skills, to expanded views of competence, to competence as a holistic concept, to reaching for excellence, to attaining excellence. While it is a developmental continuum, it is also ever-changing and its movement can go either way. Many personal and situational factors influence how well we are able to practice at any given time. We know from experience that we have times when we are close to or attain excellence and times when we are closer to different levels of competence. While we are required to be competent, our intention is always to aim for excellence.

Great tenderness in all things

The concept of tenderness in nursing probably dates back to the first century when early Christian nurses such as Phoebe and Fabiola would have drawn on the idea of expressing the tenderness of God’s love in their nursing care. It is likely that this understanding of tenderness was central in nursing practice in the Western world for many centuries. Nightingale refers to the tenderness of God in her spiritual journey (McDonald, 2001), although she appears not to have written about tenderness in nursing practice.

But for the early to mid-19th century Irish nurses, the forerunners of Careful Nursing, the expression of tenderness was central to their practice. Catherine McAuley in particular emphasized in her guidelines for the care of the sick the importance of “great tenderness in all things” (Sullivan, 2012, p. 169).

Definition

In Careful Nursing great tenderness in all things is define as:

An attitude of sensitivity, loving kindness, compassion, gentleness and patience in attending to all experiences and needs of patients. It is linked to awareness of an infinite transcendent reality and mediated through the therapeutic milieu dimensions of caritas and contagious calmness. It is proposed to infuse all nurses’ clinical attitudes and actions with the healing love of an infinite transcendent reality (Meehan, 2012, p. 2911).

In dictionaries, tenderness refers to the state or quality of being tender. Its Latin root, tendere, means to stretch towards (Partridge, 1958). Various associations with its Latin root suggest that it is associated with a quality of being exquisite, that is, of including great sensitivity, delicate beauty and intense feeling. Thus, human tenderness has the meaning of reaching towards another person showing love and concern for their welfare by being infinitesimally considerate, gentle, caring, and compassionate. The general use of tenderness in this meaning was relatively common in 1800, and in the 1820s of Catherine McAuley’s work in nursing, but it is much less commonly used today (Tenderness, 2015).

The probability that tenderness entered nursing through its association with Christianity indicates that it is a spiritual concept. Its association with love, as caritas, and compassion supports this view. The Careful Nursing historical data suggested that although it was related to the therapeutic milieu dimensions of calmness and caritas, it included a different quality. This quality seemed to be a physical, clinical action quality which had a subtly gentle but enduring powerfulness. Hence its location in the practice competence and excellence dimension where it seems to act a mirror image of its related therapeutic milieu concepts. Its clinical action quality is supported by one of the few articles about tenderness that come up in a search of nursing literature, “A little tenderness goes a long way” (Galland, 2008) which we discussed in CNN 7(2), 2015, pp. 10-19.

Literature on tenderness

No studies exploring tenderness appear in the nursing literature. In the psychology literature tenderness is viewed as an emotional component of empathy, understood as concern for the welfare of someone in need. Kalwski (2010) proposes that tenderness is experienced as an emotional surge that corresponds to the love of care-giving. His research indicated that it is a basic emotion in the same way that fear and joy are basic emotions. Luscher et al., (2011) propose that tenderness arises from a parental or parent-like concern to nurture and protect another from harm. Along with Niezink et al., (2012), they found that tenderness is distinct from sympathy and is elicited by perceiving in another, long term vulnerability and need for protection.
The absence of research on tenderness in nursing suggests that it is not recognized or valued by contemporary nurses as a nursing concept. Surely its history in nursing suggests that it warrants at least a concept analysis. The psychology studies were all conducted in laboratory settings and would serve as a basis for exploring tenderness in nursing practice settings.

**Tenderness as a nursing value**

In the 1960s tenderness was proposed as an important nursing value. In *Tenderness and Technique: Nursing Values in Transition*, Meyer (1960) uses the term tenderness to represent personal attentiveness and tender loving care in nurse-patient relationships. She contrasts it with technique, represented by knowledge and technical skill. She presents these as two important aspects of nursing which must be kept in balance, for example, she remarks that “technical competence necessarily involves tenderness” (p.7).

Meyer’s (1960) research suggested that as nurses become concerned with professionalism, they turn to technique, advanced knowledge and skills, at the expense of a concern for tenderness. She argues that tenderness must be reintegrated into nursing so that nurses practice with a synthesis of knowledge and feeling. She believes this will happen because “nursing the whole patient has given new dignity and meaning to the concept of tenderness” (p.11). Generally, this has happened, but it seems that we just do not call it tenderness any more.

**Should tenderness be retained as a Careful Nursing concept?**

The concept of tenderness has a long history of being embedded in nursing practice. Emphasis on it permeates the 19th-century Irish nurses’ work. As recently as 1960 the word tenderness was chosen to represent the healing, loving aspect of nursing practice. In 2008 Galland chose tenderness as the name of her profoundly healing encounter with a dying patient.

But for the most part tenderness has been lost from the mind of the nursing profession and words such as caring and empathy seem to have taken its place. Do we need tenderness anymore? In as much as the language of Careful Nursing must be relevant to the language 21st century nurses, do we need tenderness in Careful Nursing? My answer is yes, definitely, at least until the concept has been thoroughly examined. On the other hand, the words of some nursing students ring in my ears. Shifting uneasily in their lecture hall seats they say, “that’s over the top, get rid of it”.

So, what do you think at Saint Clare’s Health System? Maybe you would take a poll: yes? or no? Should we keep the concept of tenderness in Careful Nursing? And, Sue Weaver, sueweaver@saintclares.org would be very keen to hear any additional thoughts you might have on tenderness as a nursing concept.

Now that the new academic year has started some will soon be looking for a term paper or thesis topic. Is there an intrepid nurse at Saint Clare’s who would be willing to take the plunge and examine the concept of tenderness in nursing?

**References**


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The DAISY Award is a nationwide program that rewards and celebrates the extraordinary clinical skill and compassionate care given by nurses every day. Since 2011, Saint Clare’s has been proud to be a DAISY Award Hospital Partner and has presented 35 DAISY awards to its nurses.

DAISY NURSES

Mary Sanders, Patient Advocate, Guest Services & Patient Experience, was presented with a DAISY award at the September 16th Nurse Executive Council meeting because on a daily basis, Mary shows compassion expected from a nurse, but on one day in particular, her actions extraordinary - yet, we are sure that Mary felt that she was only doing her job.

Recently, Mary was in her car, on her way home after working a full shift when the charge nurse in the ER called her to let her know that the ER was expecting two patients in cardiac arrest, one of whom was only 28. Without hesitation, Mary came back into the hospital to lend a hand. Unfortunately, the young patient did not make it. Mary was 

KUDOS

Congratulations to Marilou Barros, RN-BC, staff nurse ACIS, who passed the ANA in Psychiatric-Mental health Nursing Certification Exam.

Congratulations to Grace Carcich, MSN, RN, Director of Education Services and CPR Training, who was appointed to the Association of Nursing Professional Development (ANPD) Recognition Committee.

Congratulations to Denise Cusick, MSN, RNC, FNP, Quality Management Specialist who received her MSN as a Family Nurse Practitioner from Walden University.

Congratulations to Carolyn Pfeiffer, BSN, RN, staff nurse Maternal-Child who received her BSN from Walden University.

Congratulations to Dawn Ward, BSN, RN, CEN, staff nurse Emergency Department, who passed the Emergency Nurse Certification Exam.

Congratulations to the following Saint Clare’s nurses who were elected to the following New Jersey State Nurses Association Region One positions:

President-Elect – Sandy Foley, MSN, RN, Staff Nurse ED
Vice President for Membership – Darlene Borromeo, BSN, RN, BC, Operations Manager PICU
Vice President for the Institute for Nursing – Vivek Agnihotri, DNP, RN, CCRN, APN-BC, Staff Nurse CCU
Vice President to the Congress on Policy and Practice – Diane Hassa, MSN, RN, Education Specialist
Nominating Committee – Sue Weaver, MSN, RN, CRNI, NEA-BC, Education Specialist

UNVEILING OF DAISY STATUES

Recently DAISY Sculptures were unveiled at the Denville, Dover and Boonton in tribute to Saint Clare’s nurses for the extraordinary compassionate care they provide to patients and families every day. The sculpture is hand carved by an African sculptor of the Shona Tribe of Zimbabwe. Most of the self-taught sculptors of Zimbabwe have never seen the art of the west. They gather their own carving stone from the mountains and plateaus where they live and farm and most still make their own tools from found objects. The flowing, connectedness of the sculpture also reminds us of the bond of care and trust that exists between healer and patient, unbroken, one flowing into the other in the unique, caring reliance.

The DAISY Award is a nationwide program that rewards and celebrates the extraordinary clinical skill and compassionate care given by nurses every day. Since 2011, Saint Clare’s has been proud to be a DAISY Award Hospital Partner and has presented 35 DAISY awards to its nurses.
there to comfort the patient’s sister, who was initially the only family present. As more family showed up, Mary was prepared to make them comfortable, to offer a hug and solace. With the family was a small child, the nephew of the deceased patient. While the family was distraught with grief, Mary stayed with the child for nearly two hours. She watched television with him, offered to help him with his homework, and even took him to the vending machine, offering to buy him anything he wanted with her own money.

Mary is known throughout the hospital as a problem solver. She deals daily with patient and family complaints, yet she never loses her compassion and her desire to help.

Mary Pawar, BSN, RN, CCRN, Staff Nurse ICU, was presented with a DAISY award at the September 16th Nurse Executive Council meeting because of the following letter that was received from a family.

Mary Pawar is the truest definition of a nurse. She is compassionate, caring, patient and kind. Our father passed away in the ICU Dover. We truly believe if it had not been for Mary we may not have gotten through. Mary had been his nurse for only a few days, but in that time, she not only gained his trust but managed to keep him comfortable and feel safe. Our parents were together for 67 years; not only did Mary give comfort to our dad but our mom as well. She walked her through each step and assuring her all the way.

Additionally, I was returning from vacation in the Washington, D.C. area when I got the call that my Dad took a turn for the worse. After he passed, Mary kept him in his room until I arrived to allow me a few last moments with him. I will never forget how she cared for the whole family.

Saving the lives of total stranger’s every day is remarkable in of itself, but when our dad passed it was evident that Mary felt it too. We feel this nurse should be honored for the dignity, respect and compassion she shows her patients every day. Thanking her from the bottom of our hearts.

WELCOME TO...

Amanda DeRoma, RN – RRC
Carlo Duran, BSN, RN – PICU
Jacqueline Huntorton-Anderson, BSN, RN – PICU
Sharon Kweit, BS, RN – RRC
Jasmine Lopez, BSN, MBA, RN – Shift Administrator
Victoria Mauro, RN – PES
Stephanie Serovich, RN, CCRN – Nurse Epidemiologist
Magdalena Siudmak, BSN, RN – PICU
Andrew Theodore, RN – 4B

MUST READ


At least half of my thirty year nursing career has been dedicated to the field of Oncology Nursing. I have been privileged to work the spectrum of cancer care from diagnosis to death. The book, Midwife for Souls by Kathy Kalina, is a book about Hospice Care but it is so much more than that. The author compares the similarities of the beginning of life with the end of life. Just as midwives help deliver a baby into earthly life, a hospice nurse or caregiver helps deliver a soul into eternal life.

Midwife for Souls has taken me on an extraordinary spiritual journey into the end stages of a person’s life, but has also helped me to remember that I am only a guest on this path with the patient and family. We must be sensitive to their family dynamics, culture and religion.

Speaking of religion, this book has shown me the unique opportunities that we have to pray with others, no matter what their religious preference or lack thereof. There is a treasure trove of prayers in this book composed by the author. They include prayers for hope, forgiveness, fear, and suffering.

Midwife for Souls is a must read. I thank God for trusting me to take care of, and be present to, those patients who are in the delicate balance between life and death.

Karen Costello, BSN, RN, CRNI, IV Team
RESEARCH ROUNDUP: NURSES’ POWER

As patient advocates, nurses use power to impact patient outcomes. “...power is defined as the ability to attain goals...” (Fackler, Chambers, & Bourbonniere, 2015, p. 267). If you want to be entered to win this book *Midwife for Souls*, send an email to Sue Weaver, sueweaver@saintclares.org. In a qualitative research study, using a hermeneutic phenomenological approach, the lived experience of power to hospital clinical nurses was explored. These nurse researchers interviewed 14 hospital ICU and medical unit nurses from two medical centers in the northeast US asking about an experience they had in which they felt powerful or powerless (Fackler, Chambers, & Bourbonniere, 2015). Three major themes were identified from the data analysis:

I. Knowing my patient and speaking up for them. The following exemplar illustrates the power of persistence -

“If a patient is cold, if a patient is feverish, if a patient is faint, if he is sick after taking food, if he has a bed-sore, it is generally the fault not of the disease, but of nursing.”

Florence Nightingale, Notes on Nursing, 1860

II. Working to build relationships that benefit patients. Nurses explained the importance of collaboration, teamwork and building positive relationships with other nurses and physicians as a foundation of power.

III. Identifying my powerful self. Experienced nurses recognized their power and influence in detecting subtle changes in patients.

This research identified how nurses use power to improve patient care and impact patient outcomes. Think about how you use power when taking care of your patients and observe how other experienced nurses use theirs.

Reference:

Editor

“One’s feelings waste themselves in words; they ought all to be distilled into actions which bring results.”

Florence Nightingale

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Saint Clare’s Nursing Research Council has a new listing on Private Sites, SCHS Intranet. The site is open access to all nursing staff and contains folders and documents for meeting minutes and agendas, research applications, literature for review, etc.

American Nurses Association has just released the Third Edition *Nursing: Scope and Standards of Practice*

Standard 1: Assessment
Standard 2: Diagnosis
Standard 3: Outcomes identification
Standard 4: Planning
Standard 5: Implementation
Standard 5A: Coordination of care
Standard 5B: Health teaching and health promotion
Standard 6: Evaluation
Standard 7: Ethics
NEW Standard 8: Culturally congruent practice

*It has been recognized that nurses need to address culture as an essential part of planning and providing care.*

Standard 9: Communication
Standard 10: Collaboration
Standard 11: Leadership
Standard 12: Education
Standard 13: Evidence-based practice and research
Standard 14: Quality of practice
Standard 15: Professional practice evaluation
Standard 16: Resource utilization
Standard 17: Environmental health
RX CORNER: OBTAINING THE BEST POSSIBLE MEDICATION HISTORY

The Institute for Healthcare Improvement defines medication reconciliation as the following: the process of creating the most accurate list possible of all medications a patient is taking – including drug name, dosage, frequency, and route – and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patients at all transition points within the hospital. Potential consequences of failing to perform accurate medication reconciliation include inadvertently omitting needed medications, duplicating therapy, or prescribing incorrect dosages. These scenarios place the patient at increased risk for adverse drug reactions and re-admission back into the hospital.

One of the most important aspects of medication reconciliation is obtaining a comprehensive and accurate list of the medications the patient is taking prior to admission. Obtaining an accurate medication history can be challenging for a number of reasons including the severity of illness, altered mental status, or simply unfamiliarity with the medications one is taking. In these situations, family members and/or the patient’s home pharmacy may need to be consulted.

The following are some tips for obtaining the best possible medication history:

1) Ask the patient which pharmacy they normally use to fill their prescriptions and document this information in Cerner. This can be used by either the person completing the medication history or other healthcare professionals wishing to clarify information with the patient’s home pharmacy.

2) The patient may find it difficult to recall all medications they take, particularly if they do not have a list. The following are some questions that may be helpful in prompting the patient to recall all medications they take:
   a. What medications do you take every day?
   b. Do you take any over-the-counter medicines?
   c. Do you take any medications for allergies?
   d. Do you take any medications to help with breathing?
   e. Do you take any medications to help with pain?
   f. Do you take any vitamins or herbal supplements?
   g. Have you taken any antibiotics within the last 2-3 weeks?
   h. Are you wearing any medication patches?
   i. Is there anything else you take that has not been mentioned?

3) Remember to ask about eye/ear drops, topicals, and inhalers. Patients often will only think of oral medications when providing a history.

4) Be sure to clarify with the patient how many times a day they take each medication. Patients may state that they take 100 mg of a medication daily when, in fact, they take 50 mg twice daily.

5) Many medications come in different dosage forms (i.e. metoprolol tartrate vs. metoprolol succinate, bupropion IR vs. SR vs. XL). If the particular dosage form cannot be verified, please indicate that in the comments section, rather than choosing a product at random.

Patients should be encouraged to always carry an accurate list of all medications they take. The below link provides a helpful template that can be used to keep track of current medications and changes. It also includes areas for the patient to document information regarding their home pharmacy, emergency contacts, physicians they see, allergies, and prior immunizations.

https://www.ismp.org/newsletters/consumer/alerts/ISMP_Med_Form_PDF.pdf

References:

Christina Varvatsis, PharmD, BCPS
Clinical Pharmacist

CHECK IT OUT -
There is now a website with great information about Careful Nursing
www.carefulnursing.ie
A LOOK BACK IN TIME

Nurses balance increasingly complex and frequently unpredictable nursing challenges over the course of a shift. Today we are responsible for helping to stabilize dangerous cardiac problems, caring for patients unable to breathe without mechanical intervention, protecting those intent on hurting themselves, detoxing the chemically dependent, redirecting the demented, administering dozens of medications while simultaneously delivering comfort and support to patients and families. Truly, the list of nursing tasks we may perform is too myriad to list.

Nurses may leave their shift feeling exhausted, worried about patients, and ready to do it all again in the morning. Our career is not for the faint of heart. As I looked back into our history, I found that, in spite of the challenges we face today, there is so much we can be grateful for that those who went before us did not have when working in other countries, and certainly in wartime situations. I think we can all be grateful we do not face them in our daily work.

1) We care for the sick but we do not have to bring the raw materials. Clara Barton, according to the National Park Service, did not just tend to soldiers on the bloodied battlefield, she used her own supplies which took her a year to collect. Following one of the most devastating battles in the Civil War -- Antietam -- she tended to the many injured and provided dressings for wounds and surgical sites which were previously being dressed with corn leaves by surgeons.

2) We don isolation gear but we can remove it when we exit and are not subjected to extremes of temperature. During World War II nurses stationed in jungle hospitals in Burma and India worked under primitive conditions - at times the malarial rate was above 80 percent of manpower. Personnel wore protective clothing at night regardless of unbearable jungle heat. Scrub typhus, with a 30% mortality rate, required intensive nursing. In spite of this, many of the nurses who served in this theater stayed longer than required although they received little recognition for it, based on the brochure “Army Nurse Corps” prepared in the U.S. Army Center of Military History by Judith A. Bellafaire.

3) We practice nursing in a relatively safe environment with little chance of being harmed or killed in the course of our care. Based on the same brochure, in another part of the world, “There was an attack on Hospital 1 which scored a direct hit killing or seriously wounding more than one hundred patients”. . . a nurse recounts . . . “The sergeant pulled me under the desk, but the desk was blown into the air, and he and I with it. . . . My eyes were being gouged out of their sockets, my whole body felt swollen and torn apart by the violent pressure. . . . I dragged myself to my feet. . . . Bodies and severed limbs hung from the tree branches. Although the nurses knew that nothing could be done to prevent further air attacks, they carried on. . . ."

4) We have easy access to doctors and abundant resources -- we do not risk our lives going to work and have a lot of support once we get there.

According to The New York Times, (1/18/1931 edition, p. 117) patients on the “lonely, almost trackless counties, high up in the Kentucky mountain” were cared for by nurses of the Frontier Nursing Service. “With little concern for her own safety . . . by horse “through snow and treacherous ice” and with kerosene lanterns, the nurses of this service called on expectant mothers, the sick and also “seeing the latest arrivals through the early days of their lives” teaching families about sanitation, protection from rattlesnakes, insects, treatment of hookworm and avoiding unsafe water. In serious cases, a doctor could be requested but it might take up to three days (and a change of horse) for one to arrive.

Our challenges are vastly different from the ones listed above, but certainly they are no more extreme. It may help to remember that we are following in the footsteps of brave and noble souls who paved the way for us, as we do now, for the nurses of tomorrow.

Reference


Beth Smith, BSN, RN, PCCN
Staff nurse, IMCU/Telemetry

Walter Reed Medical Center circa 1917-1918 during flu pandemic

The American Nurses Association position statement on immunizations states, “All health care personnel (HCP), including Registered Nurses, should be vaccinated according to current recommendations for immunizations of HCP by the CDC and Association for Professionals in Infection Control and Epidemiology” (ANA Position Statement on Immunizations, 2015, p.1). For more information visit the ANA immunize website and take the Vaccine Quiz! http://www.anaimmunize.org/vaccine/settings/acute care nursing/default.aspx
BELIEVE IT OR NOT! FLU SEASON IS UPON US AGAIN STARTING OCTOBER 1ST!

The flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. It can cause mild to severe illness, and at times can lead to death.

Influenza viruses are spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near a susceptible person). Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only a short distance through the air. Contact with respiratory-droplet contaminated surfaces is another possible source of transmission.

The typical incubation period for influenza is 1-4 days (average: 2 days). Most healthy adults may be able to infect others beginning 1 day before symptoms develop and up to 5 to 7 days after becoming sick. Some people, especially young children and people with weakened immune systems, might be able to infect others for an even longer time.

Certain populations are at greater risk for serious complications if they get the flu. This includes older people, young children, pregnant women and people with health conditions such as asthma, diabetes, or heart disease.

The best way to prevent the flu is by getting a flu vaccine each year. The seasonal influenza vaccine is developed based upon scientific research that indicates which viruses are circulating and likely to cause illness for the upcoming season. Flu viruses are constantly changing, so the vaccine is updated each year based on which influenza viruses are causing illness, how viruses are spreading, and how well the previous season's vaccine protected against those viruses.

2015-2016 Vaccine Composition:

Vaccines that give protection against three viruses are called trivalent vaccines. Vaccines that give protection against four viruses are called quadrivalent vaccines. Saint Clare's will be using the quadrivalent vaccine this year which will provide protection against two influenza A viruses (an H1N1 and an H3N2) and two influenza B viruses (Yamagata and Victoria lineages).

Seasonal influenza outbreaks can happen as early as October, and most of the time influenza activity peaks in January or later. Since it takes about two weeks after vaccination for antibodies to develop in the body that protect against influenza virus infection, it is best that people get vaccinated early so they are protected before influenza begins spreading in their community.

Source: CDC (http://www.cdc.gov/flu/keyfacts.htm)

Care of Patients with influenza:

1. All patients admitted with Flu-like Symptoms must be placed on Droplet Precautions and placed in a private room.
2. **Rapid Flu (dry swab) Screening Test:** Initial test ordered for suspected Flu.
3. **FLU PCR Test:** If Rapid Flu is negative, and patient is admitted with Flu-like symptoms, the FLU PCR test should then be ordered. Request a FLU PCR order from the physician.
4. Patient must remain on Droplet Precautions until FLU PCR results are received.
5. If the FLU PCR results are positive, notify the physician or I.D. physician (if they are on the case).
6. **Flu-positive patients must remain on Droplet Precautions for 7 days from Admission.**
7. All staff must wear a surgical mask when entering the suspected or confirmed flu patient’s room. Patients on Droplet Precautions must wear a surgical mask when out of the room and being transported to other areas.

**FLU VACCINE FAQ’S**

Q. My patient was admitted with Influenza and they did not receive the FLU vaccine this season. Should they still receive the FLU Vaccine before discharge?

A. If a person has been sick with the flu, they should still get the flu vaccine, even if they’ve already had the flu this season. This is because the vaccine protects against three or four strains of influenza. Even if someone has had the flu, they may have been infected by only one of the
strains in the vaccine. If they don’t get the vaccine, they’re still at risk of getting sick from the other flu virus strains. (Source: CDC.gov)

Q. Can the flu vaccine give me the flu?
A. No, a flu vaccine cannot give you the flu. Flu vaccines that are administered with a needle are currently made in two ways: the vaccine is made either with a) flu vaccine viruses that have been ‘inactivated’ and are therefore not infectious, or b) with no flu vaccine viruses at all (which is the case for recombinant influenza vaccine).

In randomized, blinded studies, where some people got flu vaccines and others got saline vaccines, the only differences in symptoms was increased soreness in the arm and redness at the injection site among people who got the flu vaccine. There were no differences in terms of body aches, fever, cough, runny nose or sore throat. (Source: CDC.gov)

Q. Why do some people not feel well after getting the flu vaccine?
A. The flu vaccine can cause mild side effects that are sometimes mistaken for flu. People sometimes experience a sore arm where the vaccine was given. Soreness is often caused by a person’s immune system making protective antibodies in response to being vaccinated. These antibodies are what allow the body to fight against flu. The needle stick may also cause some soreness at the injection site.

Rarely, people who get the flu vaccines have fever, muscle pain, and feelings of discomfort or weakness. If experienced at all, these effects usually last 1-2 days after vaccination and are much less severe than actual flu illness. (Source: CDC.gov)

Q. What about people who get a flu vaccine and still get sick with flu-like symptoms?
A. Individuals may be exposed to an influenza virus shortly before getting vaccinated or during the two-week period that it takes the body to gain protection after getting vaccinated. This exposure may result in a person becoming ill with flu before the vaccine begins to protect them. People may become ill from other (non-flu) viruses that circulate during the flu season, which can also cause flu-like symptoms (such as rhinovirus).

A person may be exposed to an influenza virus that is not included in the seasonal flu vaccine. There are many different influenza viruses that circulate every year. The flu shot protects against the 3 or 4 viruses (depending on whether the flu shot is a trivalent or quadrivalent vaccine) that research suggests will be most common. Unfortunately, some people can get infected with an influenza vaccine virus despite getting vaccinated. Protection provided by influenza vaccination can vary widely, based in part on health and age factors of the person getting vaccinated. (Source: CDC.gov)

Sarah Granda, MSN, RN
Infection Control Department

NDNQI RN SURVEY

All DIRECT Care RNs who work full-time, part-time, or per diem at Saint Clare’s are invited to participate in the National Database of Nursing Quality Indicators (NDNQI) RN Survey. The survey is available through October 25, 2015 for RNs who spend at least 50% of their time in direct patient care responsibilities and have been employed on the unit a minimum of 3 months. RNs will receive an email with information on how to access the survey at https://members.nursingquality.org/rsurvey

This is the sixth year that Saint Clare’s Health System will be participating in NDNQI® (National Database for Nursing Quality Indicators) RN survey, and it is an important aspect of the Pathway to Excellence. This year we will once again be obtaining additional information about the nursing practice environment at Saint Clare’s. The survey focuses on the following areas:

I. Nurse Participation in Hospital Affairs
II. Nursing Foundations for Quality of Care
III. Nurse Manager Ability, Leadership, and Support of Nurses
IV. Staffing and Resource Adequacy
V. Collegial Nurse-Physician Relations

The survey results will be received by December 2015 and will be shared with Nurse Practice Council. Please contact Sue Weaver, sueweaver@saintclares.org if you have any questions.

Sarah Granda, MSN, RN
Infection Control Department

The owner of the stethoscope does not matter. We are all members of the healthcare team.

Pictured Left to right: Adrienne Peck, RN, Jackie Galante, BSN, RN, Dr. Brian Schnager, Danielle Zimmerman, BSN, RN, and Will Concho, RN
**BLOOD TYPE SODOKU**

It’s a good thing that donating blood is easier than solving a Sudoku puzzle! Using each blood type (O+, O-, A+, A-, B+, B-, AB+, AB-) and M for bone marrow, place each element once in each 3x3 box so that each column and each row contains each element only once.

```
O+   | O-   | B-   |
A+   | B+   | AB+  |
O+   | AB+  | B+   |
A-   | O-   | AB-  |
A-   | AB-  | M    |
A+   | AB+  | A-   |
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<td>11-5-2015</td>
<td>8:30am-3:30pm</td>
<td><strong>When Chaos Strokes! Earn Contact Hours</strong></td>
<td>DOVER Training Center</td>
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<td>To register contact <a href="mailto:Jeanmariechiappa@saintclares.org">Jeanmariechiappa@saintclares.org</a> or 973-537-3838</td>
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<tr>
<td>11-10-2015</td>
<td>8am</td>
<td><strong>Medical Grand Rounds “Bladder Awareness Week: Diagnosis and Management of Overactive Bladder, Interstitial Cystitis, and Pelvic Floor Disorders”</strong></td>
<td>DENVILLE Urban Auditorium</td>
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<td>Michael Ingber, MD Department of Surgery, Urology/Urogynecology</td>
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<td>11-12-2015</td>
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<td>To register contact <a href="mailto:johnkrslic@saintclares.org">johnkrslic@saintclares.org</a> or 973-537-3801</td>
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<td><strong>Medical Grand Rounds - Obesity</strong></td>
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<td>Christopher D. Still, DO, FACN, FACP</td>
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<td>Medical Director, Center for Nutrition &amp; Weight Mgmt.</td>
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<td>Director, Geisinger Obesity Research Institute;</td>
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<td>Medical Director, Employee Wellness, Geisinger Health System, Danville, PA</td>
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<td><strong>Who wants to be a charge nurse?</strong> Sign Up in LEARN Earn 2 Contact Hours</td>
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<td>11-19-2015</td>
<td>8am-11am</td>
<td><strong>CNJNE IV Course</strong> Earn Contact Hours To register contact <a href="mailto:SueWeaver@saintclares.org">SueWeaver@saintclares.org</a> or 973-537-3811</td>
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<td>7:45am-12Noon</td>
<td><strong>Diabetes Conference Earn Contact Hours</strong> To register contact <a href="mailto:Jeanmariechiappa@saintclares.org">Jeanmariechiappa@saintclares.org</a> or 973-537-3838</td>
<td>DOVER Conference Room A</td>
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<td>11-24-2015</td>
<td>8am</td>
<td><strong>Medical Grand Rounds</strong> “<strong>Addressing Challenging Cases in the Management of DMD Therapy for MS</strong>” Suhayl Dhib-Jalbut, MD</td>
<td>DENVILLE Urban Auditorium</td>
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<td>11-23-2015</td>
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<td><strong>ACLS Prep class to review EKG and Pharmacology</strong> To register contact <a href="mailto:Jeanmariechiappa@saintclares.org">Jeanmariechiappa@saintclares.org</a> or 973-537-3838</td>
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<td>11-24-2015</td>
<td>8am-4:30pm</td>
<td><strong>PALS Full Course</strong> To register contact <a href="mailto:Johnkrsulic@saintclares.org">Johnkrsulic@saintclares.org</a> or 973-537-3801</td>
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<td>11-25-2015</td>
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<td>12-1-2015</td>
<td>8am</td>
<td><strong>Medical Grand Rounds</strong> Chronic Obstructive Pulmonary Disease: Strategies to Improve Care and Reduce Hospital Readmissions Jennifer D. Possick, MD</td>
<td>DENVILLE Urban Auditorium</td>
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<td>12-1-2015</td>
<td>8am-4:30pm</td>
<td><strong>Basic Arrhythmia Course conducted over 4 dates, 12/1, 12/2, 12/15, and 12/16 Sign Up in LEARN Earn Contact Hours</strong></td>
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<tr>
<td>12-3-2015</td>
<td>2PM-2:30PM</td>
<td><strong>ACLS Prep class to review EKG and Pharmacology</strong> To register contact <a href="mailto:Jeanmariechiappa@saintclares.org">Jeanmariechiappa@saintclares.org</a> or 973-537-3838</td>
<td>DOVER Training Center</td>
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<td>12-4-2015</td>
<td>8am-9am</td>
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**Staff Writer:** Megan Weller, BSN, RN  
**Staff Writer:** Beth Smith, BSN, RN

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- Janice Lynch, MSN, RN, Regional Nurse Executive, Nurse.com

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