SIGMA THETA TAU INTERNATIONAL

2014 RNL

Reflections on Nursing Leadership

YEAR-END SAMPLER

Sigma Theta Tau International
Honor Society of Nursing®

Dear Colleague,

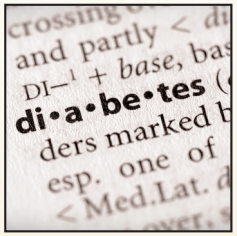
2014 has been a wonderfully eventful year at the Honor Society of Nursing, Sigma Theta Tau International (STTI)—full of growth, exciting challenges, and great opportunities.

It is with gratitude and pleasure that we present to you this year-end sampler, highlighting some of the best articles from *Reflections on Nursing Leadership*, our online member magazine. We've chosen several of our personal favorites to share with you, and we hope you will enjoy them as much as we enjoyed bringing them to you. It's a small way of giving back to you for supporting STTI's efforts not only to publish books, scholarly journals, and articles on informative and relevant topics for nurses, but also to ultimately improve global health through the many and varied STTI programs, events, and relationships.

Thank you for your engagement and support, allowing STTI to fulfill its mission of advancing world health and celebrating nursing excellence in scholarship, leadership, and service.

We wish you all the best in the coming year.

Cynthia Vlasich
Director, Global Initiatives
Interim Director,
Education and Leadership







Dear Reader,

As editor of *Reflections on Nursing Leadership* (*RNL*), I am pleased that content from the magazine has been chosen as a way to express our appreciation for all you do. In making our selections, we have sought to choose those that reflect not only excellent writing and storytelling, but also the diversity and interests of STTI members. Here's what we have for you in this special year-end sampler:

Guillermina "Mina" Rincon Solis, PhD, APRN, FNP-C (Delta Chapter), is a nurse educator with The University of Texas at El Paso, but she wasn't always a teacher. Once in academia, she realized that, in addition to teaching, her new role required her to conduct research and publish. She also found that no experience is wasted and writes about it in "MOVING FROM CLINICIAN TO SCHOLAR-RESEARCHER? REMEMBER YOUR ROOTS."

In "YOUR BSN AND THE PUBLIC," Jennifer Shearer, PhD, RN, CNE (Gamma Omicron-at-Large Chapter), assistant professor, Medical University of South Carolina College of Nursing, suggests that bedside hospital nurses are public health nurses, whether they realize it or not.

Shukrullah Ahmadi, BScN, RN (Rho Delta Chapter), a recent graduate of Aga Khan University School of Nursing and Midwifery in Karachi, Pakistan, is now a surgical care coordinator at the French Medical Institute for Children in Kabul, Afghanistan. In "THROUGH THE EYES OF CHILDREN," he observes that women aren't the only ones affected by domestic violence in that war-torn country.

Meg Moorman, PhD, RN, WHNP-BC (Alpha Chapter), assistant clinical professor at Indiana University School of Nursing, was intrigued when she was introduced to Visual Thinking Strategies, a teaching method used in primary education. In "CURE FOR FUZZY THINKING?" she shows how the method, when applied to nursing education, promotes critical thinking and appreciation for ambiguity.

Three years ago, Tiffany Montgomery, MSN, RNC-OB, C-EFM (Gamma Tau-at-Large Chapter), began pursuing her PhD degree at the University of California, Los Angeles (UCLA), and readers have accompanied her on her quest via her *RNL* blog, "Taking hold of my dreams." Recently, she told them about another journey, this one to Southeast Asia. She wrote about it in "MATERNAL-CHILD HEALTH NURSING IN INDONESIA."

Finally, Cynthia "Cindy" Clark, PhD, RN, ANEF, FAAN (Mu Gamma Chapter), professor at Boise State University School of Nursing, normally writes about civility, both in education and in the workplace. In "IT WAS THE NURSES!" she writes about an entirely different topic. You won't want to miss it!

During this season of giving, thanks again for the many ways you give year-round. The world would not be the same without you.

James E. Mattson
Editor, *Reflections on Nursing Leadership*

Moving from clinician to scholar-researcher? Remember your roots.

Guillermina 'Mina' Rincon Solis, PhD, APRN, FNP-C, GNP-C (Delta Chapter), teaches in the online graduate program at The University of Texas at El Paso.

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Sometimes, looking back is good.

When I entered academe as a nurse educator, I thought I would be teaching future nurse practitioners. I gave little consideration to the fact that, in addition to teaching assignments and service, scholarly work calls for publishing and conducting scientific research. During my first year of teaching, I was surprised when I was asked to participate in research projects and contribute to writing grant proposals and manuscripts. I felt inept, overwhelmed, and surprised that I would have to do this.

If you are starting a career as a nurse educator, you need to know that advancing in academe will require expanding your role to include that of scholar-researcher. This change may take you out of your comfort zone and make you feel like you need to start all over—but you don't. Knowledge, skills, and previous nursing experiences can help you transition into the scholar-researcher role with confidence. Whether you are a clinician considering a faculty role or a faculty member needing to engage in scholarship to keep your teaching job, remember that you're not alone. It's important to know that you will go back to feeling like a novice when faced with scholarly expectations. Recalling your strong nursing background can be your pillar of strength and the framework that supports you in challenging situations as you make the transition.

As a nurse, I developed traits that became so deeply imprinted in me that they went unnoticed by me and unrecognized by others. Not until I was required to complete a grant-funded project, which forced me to call upon my nursing background, did I realize the value of earlier experience in helping me initiate my career as a scholar. Three nursing skills—advocacy, resourcefulness, and ingenuity—helped me make the transition. I encourage you to rediscover strengths that will help you succeed. Don't be surprised if you reclaim the same three qualities that were helpful to me.

How I turned my clinical specialty into a funded project

Knowing I needed involvement in a research program to keep my faculty position, I turned to my clinical specialty, geriatrics. As a clinician, I had observed that after a fall, many elderly patients went from being independent and confident to becoming dependent on their family and fearful of leaving their home. My interest in improving the health and safety of older adults gave me an opportunity to use my first research project to advocate on behalf of this population.

Writing a grant proposal allowed me to marry my research interest—injuries in older adults sustained from falls—with my clinical experience as a geriatric nurse practitioner. I proposed using a well-established, evidence-based, eight-week program for volunteer lay leaders titled "A Matter of Balance: Managing Concerns About Falls." The project was funded, allowing me to deliver a fall-prevention program to four groups of older adult women. The measurable outcome would be improvement in these women's knowledge, physical-activity practices, and attitudes about falls.

My elation about receiving funding turned to horror when, upon reading the funder's letter of congratulations, I realized I had six months to complete the project. I had to get materials from the company, train coaches to deliver content, recruit participants, find a place to hold classes, and coordinate class schedules.

My first challenge was finding a site, and I decided on churches. Having been a parish nurse, I knew that no one was going to answer a phone call from a researcher the week before Christmas, the busiest time of the year. So I went to them.

To meet church officials and familiarize myself with parishioners, I attended church services and daily Mass. This allowed me to ease into conversations, show interest, and convey the value of the program for women in their congregations. I made a point of contacting key people and found that introducing myself as a nurse opened opportunities to secure community partners, establish sites for holding classes, and recruit participants.

The next challenge was recruiting community volunteers to teach classes to older adult women participating in the program. My resourcefulness was tested. When I turned to retired nurses, friends, and college students for help, I knew, from previous experience as a nurse in securing buy-in for a variety of causes, that making the program personal would persuade prospects to say yes. So, I started by asking them about their experiences with falls and who in their lives had been injured by a fall. After they told me their stories about a grandmother, other relative, or friend who had fallen, I asked how things turned out. They were both sad and surprised to learn that many such falls are preventable. When they discovered that the course they'd be teaching could prevent others from falling, they agreed to volunteer.

For one of the groups, my greatest challenge occurred on the first day of class. Upon arriving, I found the classroom locked with no one to open it because of a church holiday. I was afraid of losing participants and halting the project. But ingenuity, honed by my hospital nursing experience, kicked in almost automatically and triggered an adrenaline rush. I quickly mobilized the team of coaches and volunteers to set up a picnic-style class. Without missing a beat, we borrowed umbrellas and portable chairs from nearby friends to hold class outside. It was a hot summer day, so we served Popsicles to keep participants cool. When the class was over, everyone left having had a good time and wanting to return.

What does this mean for you?

The three strengths I brought from my nursing roots to my new role as a scholar-researcher may also help you succeed in that role. Like a jewel in a treasure chest, each of the following qualities—advocacy, resourcefulness, and ingenuity—is a strength that can be used to transition from clinician to scholar-researcher.

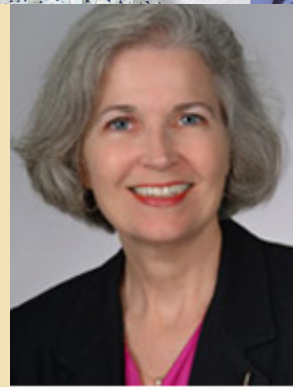
Be an advocate. When embarking on a scholarly project, take inventory of your nursing experiences, and go back to your roots to find the passion that will keep you engaged in your research and publishing projects from start to finish. I went back to my specialty area—geriatrics—to identify a fundable, meaningful research topic that moves me and fuels my program of research.

Be resourceful. When pressed with challenges, such as deadlines, do what you did as a nurse: Reach out for help. When I realized I had six months to complete my project, I relied on what I had learned as a parish nurse to make connections with church officials who would help sponsor our program.

Be ingenious. When you run into roadblocks, use courage and imagination to get around obstacles you encounter. When I found the church door locked, I borrowed from my experience as a clinician and took advantage of the inevitable adrenaline rush to quickly choreograph a picnic-style class, complete with umbrellas.

I hope the advice I offer gives you confidence to start your career as a scholar-researcher. You have all you need to succeed when you reach back to your nursing past and allow advocacy, resourcefulness, and ingenuity to move your best ideas into action on behalf of those you are passionate about serving. Strengths and abilities you have developed as a bedside nurse are assets that can contribute greatly to your success as a scholar-researcher. Don't overlook them!

Your BSN and the public



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If you are a hospital nurse, you are a public health nurse.

The 2010 Institute of Medicine (IOM) study, "The Future of Nursing: Leading Change, Advancing Health," calls for nurses to practice to the fullest extent of their education and training. Why does this have to be limited to advanced practice nurses?

Your BSN degree certifies that you have been educated and trained to assess and care for populations, but nurses who work in hospitals often do not practice to the full extent of their education. Many hospital nurses think that community or public health nursing is a course required to graduate, to be used only if they work as public health nurses. But hospital nurses also take care of the public.

More public than you think

"Public health" has been characterized inaccurately. Every day, "the public" arrives in our hospitals sicker and sicker, because formalized public health budget cuts make it difficult to effectively prevent disease. BSN-prepared nurses need to recognize that their patients are "the public"—that public health interventions are a nursing prerogative. If you have a BSN education and work in a hospital, you are a "public health" nurse.

The story has been around in public health circles for many years: A doctor is fishing in a stream when he sees a man drowning. Naturally, he jumps in to rescue him but, before getting him to shore, hears a call for help and realizes another man is drowning. Quickly depositing the first man on the shore, he jumps in to rescue the second. And just as he brings him in, more cries for help tell him another person is drowning. He wonders, "Who is upstream, pushing people in?"

The same thing happens in health care. To streamline the rescue operation and get people to hospitals more quickly, we send helicopters, rescue boats, and teams of specialists, but we wonder, "Who is pushing them in?" We have a downstream perspective, but we need an upstream viewpoint that goes to the source and stops the problem.

We know health is determined by social and environmental factors—where we live and what we do—but we prescribe and treat patients as if only drugs and therapy effect better health. After rescuing patients, we send them home and wonder why they return to the hospital, their health unimproved. Let's look upstream, where our patients spend most of their lives.

Going public

If you're a hospital nurse, you may see them only when they need rescuing, but what if you became involved in preventing disease and promoting health before your patients start to "drown?" BSN-prepared nurses need to remember their capabilities. As a hospital nurse, if you practice to the full extent of your capability, what does it look like? Who is your patient—your "public"?

In the hospital, we advocate, collaborate, coordinate, manage care, and educate, while applying research at the bedside. But every BSN graduate has also learned to screen and follow up, assess communities, build coalitions, investigate disease, provide surveillance, and contribute to policy development. To focus on prevention and improve health care delivery, these latter competencies need to be practiced.

Consider patients admitted to your unit as representing the public, a group, a population that may live in the area or beyond your hospital's community. What are you doing to know and meet their needs? Look again at functions you already perform—teaching, advocacy, and case management, to name three. Below are some ways those roles can be made more effective from a public health perspective.

Teaching: Include family members in patient education. Make education available to larger audiences by providing classes. Address culture and literacy barriers through hospital-wide media.

Advocacy: Affirm your patients. Respect human dignity by speaking out when needed and by providing resource information when patients are discharged.

Case management: Is there someone on your unit with special expertise who could become a primary resource—case manager—for a particular population? The population could be based on diagnosis or residential location, such as rural areas, inner city, low-income neighborhoods, or underserved communities. Referral is not a stand-alone intervention. It requires follow-up. Is there someone who could take that on? Make it a quality-improvement task. When referrals are not completed, find out why and plan an intervention with a population focus.

Start with awareness of upstream factors. Build relationships and learn about your patients by listening to them and really hearing what affects their health. Follow up surgical discharges with a phone call. Ask "upstream" questions and collect the data.

As nurses, we want patients to assume self-management, but we may not be aware of educational barriers that stand in the way of self-management. Use your BSN training to plan and implement intervention programs on your unit. To solve a problem, you collect data. Before planning care, you assess. Remember those community assessments you did in nursing school? Those were not just academic exercises. Under the Affordable Care Act, U.S. nonprofit hospitals are now required to do community needs assessments to receive federal funds (New requirements, 2013). Those failing to do so will be fined by the Internal Revenue Service.

Remember who you are

You can help. Researching data on your unit's population may uncover some needs and service gaps in your community. Identify barriers and be part of the solution by taking part in outreach. Every day, nurses teach to increase knowledge and change patient attitudes and behaviors. You can help families in crisis by participating in conferences or home visits. Include community nurses in those conferences.

Transportation is a barrier for some rural populations. Advocate for change by soliciting support from your hospital. And don't forget your place in developing policy. As nurses, we have power because of the trust the public puts in us. A well-written letter to the editor can promote your cause as well as the profession.

The IOM study states that health care transformation requires that nurses take on new roles and become a linchpin (the hub, the essential piece) for health reform. We can do that. We are almost 3 million strong. But we have to change the way we view the system and get out of our silos. The populations we see—those who are elderly, those who have diabetes or heart disease—are comprised of individuals. But let's not look at them only as individuals; let's also look at them as representing populations. Already, advanced practice nurses are claiming their place in primary care. BSN nurses can also move up to their full potential and care for their groups of patients by assessing group needs, implementing programs, evaluating successes (and failures), and improving what they do.

Practice to your full potential. As a BSN-prepared nurse, you are fully equipped to promote health and help protect the public, right where you are. By being creative and inspired, you can help the nursing profession be the linchpin for health reform it was meant to be.

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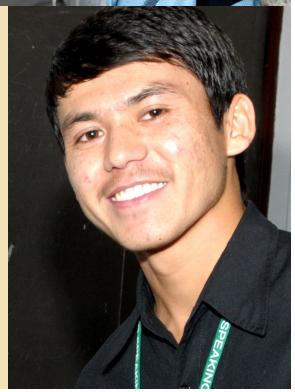

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Through the eyes of children

Despite efforts of the international community and the emergence, since 2001, of a government with democratic structures, a culture of domestic violence still continues in Afghanistan. Annual rates of violence are, in fact, increasing. Lack of peace, limited educational opportunities, economic and political uncertainty, and suppression of women's rights are factors that may be contributing to this rise in violence.

According to Tolo News, the country's leading news network, 2,500 cases of domestic violence were reported to the Afghanistan Independent Human Rights Commission (AIHRC) in the first four months of 2013, a rate higher than in previous years. In fact, 22 cases are reported to AIHRC every day, which is alarming.

Multifamily impact

Women are not the only ones affected; violence also takes its toll on children who witness it. Most Afghans live in extended-family units, so children of a family that live in one room of a dwelling often witness violence that involves another part of the family. I visited a group of 10 boys, ages 15 to 20, in a hospital, and all had witnessed violence in their families. Most had witnessed violence against their mothers, but some had observed violence visited on their sisters-in-law or other close female relatives. The perpetrators were males, frequently the family patriarch.

Often silent witnesses to violence—silence sometimes forced on them by close relatives—these young men experienced flashbacks that brought emotional pain and self-pity. Because they were young when the violence occurred and had been taught not to speak up regarding family matters, they had learned to block out these miserable realities. One of them, now grown, said: "I live with a shameful past because I failed to save my victimized mother from violence. All I could do was to observe, scream, and weep. Everything passed in silence."

Suffering in silence

This reality is normal for most Afghan children who witness domestic violence. They suffer in silence, unable to act. The perpetrators, on the other hand, feel honorable about what they do, unaware of the psychosocial consequences their actions have on their children.

Mental images of violence they witnessed haunted the boys and were psychologically painful. One said: "I had to pay the price for it for no reason. Because of the disturbance and noise caused by violence, I couldn't concentrate. I had to leave the house in order to study."

These examples clearly demonstrate the inevitable negative impact of violence on children. The boys I spoke with were worried about effects of the violence they had witnessed, as it negatively impacts their mental health and overall development, especially personality development. They recognize that what they have observed increases the likelihood they will use violence as a tool to resolve issues.

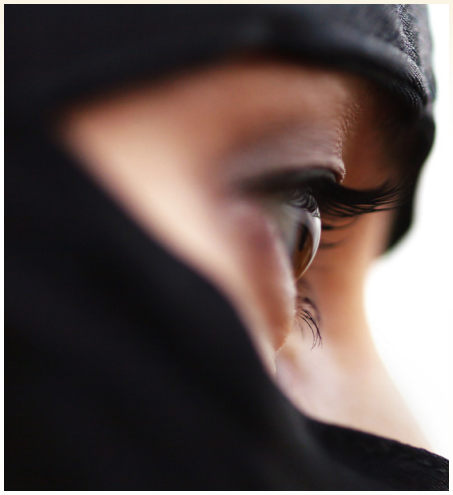
Cultural change comes slowly

Lack of education, incompatibility of partners, poverty, and traditional patriarchal culture, combined with religious traditions that are contrary to true Islamic beliefs—such as treatment of women as a commodity—make Afghan women more vulnerable. Although Islam promotes equal rights and better treatment of women, misinterpreted teachings are disastrous for women. Educating people about women's rights, in light of Islamic teaching, can help resolve this, but changing cultural practice may take many generations.

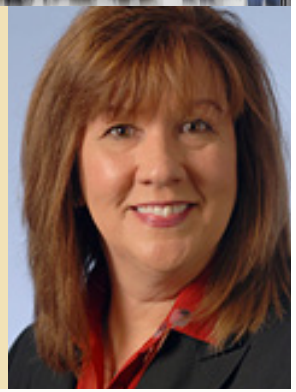
Domestic violence is turning into a significant social, human rights, and public health concern. Reforms in the country's laws, such as development of Afghanistan's Constitution in 2004 and endorsement, in 2009, of the Law on Elimination of Violence against Women (EVAW), are worthy achievements. Although these laws criminalize violence and protect women's rights, the reforms seem very formal and could be easily reversed because they appear to conflict with traditional, much-practiced beliefs.

An obvious example of the struggle between reform and tradition is a statement by the National Ulema Council that women are secondary to men and that violence against women is acceptable, to some extent, by Sharia law. (The Afghan National Council of Ulema, composed of 3,000 mullahs from across the country, serves in an advisory capacity to President Karzai about Muslim moral, ethical, and legal issues.)

After 2014, when the international community is scheduled to withdraw its interventions and aids, there will be a dire need for additional national and international efforts to reduce domestic violence. At the grass-roots level, it's important to educate women about the issue. If reducing domestic violence is not given the attention it deserves, Afghanistan's culture of violence will continue, with life-threatening implications for the women who experience violence and emotional pain for the children who witness it.



Cure for fuzzy thinking?



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VTS promotes critical thinking and appreciation for ambiguity.

Nurse educators are often expected to use creative, innovative teaching strategies that engage students, teach concepts and content, and help support a student's ability to communicate. This can be difficult, given credit hours, heavy content load, time limitations, and large class sizes.

Visual Thinking Strategies (VTS), a teaching method widely used in primary education, involves taking young students to an art museum for conversations about art with a trained facilitator. This curriculum-based teaching method and these conversations have been shown to improve communication and critical thinking for these young students. VTS has not been widely used, however, in adult education and, more specifically, in nursing education. As a new nurse educator, I started using it several years ago, and my students loved it. I wanted to find out why, so I started researching the subject.

I was introduced to VTS during my first year as an educator when I went to a lecture by Daniel Pink, author of *A Whole New Mind.* He discussed creativity and innovation in today's world and mentioned a medical school that was using art to teach observational skills to medical students. I sent him an email asking for more information. He responded immediately and identified the study he had referred to, which used a modified version of VTS.

When I mentioned this to a friend, she informed me that our local art museum had trained VTS facilitators, and she happened to know someone with whom I could work. So I took a group of volunteer students to that art museum one evening, and we were introduced to Visual Thinking Strategies, which later became the subject of my doctoral dissertation. As I watched students engage with art, participate eagerly, and discuss ways they could use this technique in their nursing care, I wanted to know more!

Abigail Housen and Philip Yenawine, developers of Visual Thinking Strategies, initially developed the technique as a way to engage people with art. The average person looks at a work of art for approximately three seconds and then moves on to view the next creation. Working with small groups of approximately 10 viewers, VTS uses trained facilitators (usually docents at art museums) to view art interactively. As participants gather around a work of art—a picture, for example—the facilitator asks, "What is going on in this picture?" When someone responds, the facilitator paraphrases the responder and says, "Tell me what you're seeing that makes you say that," thus prompting the participant to provide evidence for what he or she said and to use evidential reasoning.

Nothing is taken for granted. As the observer explains how he or she came to the proffered conclusion, the group has the advantage of hearing how the original response was developed. Based on theories developed by educational philosopher Lev Vygotsky, VTS uses social interactions to help learners, and this social discussion process gives the group the opportunity to hear out loud how others perceive and think about what they observe. This aids in critical thinking.

Works of art chosen for VTS analysis tend to be a bit abstract, to allow for multiple interpretations. By seeking clarification from each participant and validating responses by restating them and showing no sign that any one answer is correct, the facilitator encourages active engagement with the art and closer analysis. After the initial examination and discussion, the facilitator moves on to the next key question: "What more can you find?"

This invites the whole group to look again at the artwork and to disclose other observations. In doing so, they scaffold off of each other's comments. As VTS discussions proceed, with all participants getting equal attention and no answer judged to be the right answer, the group is encouraged to consider multiple interpretations. This "tolerance of ambiguity" is important in the medical world, as there often is no right answer, no one diagnosis, and lots of ambiguity and unknowns. In an educational milieu where we teach that there is "only one right answer" and NCLEX board questions are graded by the same standard, the concept of ambiguity is often difficult for students to grasp. But in the real world, we are often left with ambiguity, uncertainty, and unknown etiologies. We don't talk much about that in nursing school.

After continued and successful offering of VTS as part of coursework in a four-year BSN program, we have invited medical students to participate. Meeting at an art museum provides a rare opportunity for various disciplines to come together on neutral territory—the art museum—with no lab coats, name tags, or scrubs and virtually no hierarchy. Discussing artwork with people from other disciplines in this "safe" environment encourages active interaction.

At the end of each discussion—each piece of art is analyzed for about 20 minutes—we ask participants how they could use this technique in their line of work, and we find that they are very innovative. They have learned to provide more detail about clinical findings and have become better listeners who are more open to considering multiple opinions.

Students have regularly applied the VTS questions used for art reviews—1) What's going on in this painting? 2) What are you seeing that makes you say that? 3) What more can you find?—to clinical situations. For example, one student who entered an ICU unit to care for a critical patient for the very first time observed: "I thought about one of the works of art we looked at for VTS. It was very complicated and overwhelming, just like the ICU patient. So, when I walked into my patient's ICU room, I started to break down all of the complicated pieces into little pieces, like we did that large work of art. Focusing on the ventilator first, I asked the respiratory therapist, 'What are you seeing that makes you think this patient needs more oxygen? What more can you tell me about this vent setting? And how did you get to that conclusion?' VTS really helped me to break down a complicated situation and ask questions of the RT."

Some students find working with doctors, social workers, and physical therapists a challenge and describe it as intimidating. "I'm afraid I don't know what they know and don't want to look stupid, so I don't really say much in group activities, such as simulations, even if I see something that might be wrong." By bringing students from various disciplines together in a safe environment, VTS helps them learn to work together and collaborate. When participants, at the end of the process, discuss how they might find VTS useful in their own disciplines, students learn about other roles in health care.

Observational skills have been shown to improve with several VTS interventions. Crime scene investigators have used VTS in New York City to improve their observational skills, and medical schools are starting to use art in a variety of ways to aid students in noticing and describing, which, in turn, helps achieve the correct diagnosis. VTS is a way to use art in medical and nursing education to improve observational skills. Nursing students say that, by providing more detail in their notes, charting, and reports to other health care workers, they are more likely to give evidence for what they see. This, in turn, promotes improved patient outcomes, a key component of good health care.

In summary, Visual Thinking Strategies is a well-studied teaching technique in primary education. Only recently used in nursing and medical education, it has the potential to help students work in groups, communicate more effectively, tolerate ambiguity, and engage in vital discussions with other health care workers. This teaching tool is a fun, effective way for health care partners to listen, observe, and learn from each other, which translates into caring for patients in a complicated health care system.

For more information about Visual Thinking Strategies, visit http://www.vtshome.org/ or contact Meg Moorman at mmmoorma@iu.edu.

Maternal-child health nursing in Indonesia

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There is so much we can learn from each other.

During winter break of my previous academic year—for those of you in the southern hemisphere, "winter" break at UCLA is in December, not July—I had the amazing opportunity to travel to Indonesia to see, firsthand, the work of front-line maternal health workers. I wrote about my experience as a guest blogger for the Frontline Health Workers' Coalition. The experience was so much more extensive than what I was able to capture in that blog post, so I am sharing more of my experiences here.

Technology and traffic

Two things I noticed in Bandung, West Java, Indonesia resonated with me more than anything else: use of text messaging by *puskesmas* (government clinic) staff and the traffic. I am a lover of technology and an advocate for use of mobile technology in health care, so I couldn't have been more pleased to see posters on puskesmas walls with instructions for texting patient-referral information to the local hospital. Clinic staff members said that lack of hospital staff to respond to the SMS gateway (the text messages used to refer patients to hospitals) was a large obstacle for them. Still, use of mobile technology among Indonesian nurses is an important step in health care delivery. I may be a bit biased, as my own research focuses heavily on mobile technology, but that's OK.

The other very noticeable thing was the traffic. As a resident of Los Angeles, California, USA, I am used to traffic. My daily activities are scheduled around high traffic times. I decide what time to wake up based on anticipated traffic. I group errands so I don't have to deal with traffic more often than necessary. I *know* traffic. However, I had *never* before experienced the type of traffic I saw in Indonesia. What should be an hour-long drive took us more than three hours. Motorcyclists bobbed in and out of lanes, all the while transporting women and children without helmets. It wasn't just the public that had to deal with traffic. Ambulances sat in traffic with us. Sirens were on, but many of the cars on the road either wouldn't move over or had no place to move to. It was no surprise that puskesmas staff members reported transporting patients to hospitals as one of their biggest obstacles.

Nursing practice of midwives in Bandung is very similar to practice of labor and delivery nurses in the United States. Here, we have critical events team training (CETT), where we use simulation to practice handling emergencies. In Bandung, the Expanding Maternal and Neonatal (EMAS) program administers similar training.

Knowledge builds confidence

EMAS focuses on three areas of maternal health and three areas of neonatal health: eclampsia, postpartum hemorrhage, maternal sepsis, low birth weight, neonatal sepsis, and neonatal asphyxia. Clinic and hospital participants of EMAS are selected based on the number of deliveries and maternal-fetal deaths at each facility. Staff training occurs in the home facility. Staff members are given modules and are responsible for training themselves, based on the notion that, if training occurs away from the home facility, midwives won't know what to do when they go back to their home facilities. I love this teaching philosophy!

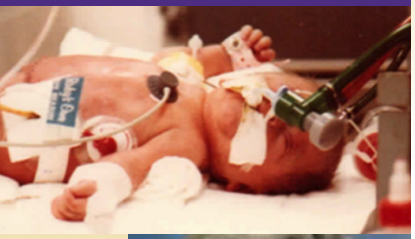
As participants in the program, puskesmas staff members are taught what to do during maternal or neonatal emergencies. The program helps increase midwife confidence in caring for high-risk women until the patients can be safely transferred to the hospital. Checklists help in emergencies, and they understand that it is within their scope of practice to administer medications such as antibiotics and magnesium sulfate. Just like American nurses, the Indonesian nurses I met use the Neonatal Resuscitation Program (NRP) model during neonatal emergencies. They also give intramuscular Methergine and intramuscular oxytocin during postpartum hemorrhages. Puskesmas nurses said they were grateful for the increased confidence they have as a result of knowledge provided by the EMAS program.

The EMAS program, which is beginning to bridge the gap between clinics and hospitals, encourages ongoing mentoring and quarterly training. The relationship is mutually beneficial for puskesmas and hospital alike. A memorandum of understanding between clinics and hospitals allows sick patients to be referred to the closest hospital. According to puskesmas staff members, the best outcomes of the program are better clinic management and use of texting to enhance communication between clinics and hospitals. EMAS has strengthened the network among physicians and midwives. Midwives are no longer afraid to call physicians, regardless of the time of day or night, an issue some U.S. nurses continue to struggle with.

Nurses are alike the world over

The puskesmas nurses told me that their greatest motivation was desire to save the lives of mothers. I could tell by their love for continuing education that this was, indeed, true. I had to travel all the way to the other side of the world to realize that nurses everywhere are one and the same. We may have different cultural practices and slightly different patient-care procedures, but we all cherish good outcomes. Going to Indonesia made me feel part of the global nursing profession. For the first time ever, I felt as though nursing was bigger than what I have known it to be in the United States. Nursing for me is now a global endeavor. Almost a decade after graduating from nursing school, I have a clear understanding of the importance of nursing practice, both inside and outside of my country.

I hope to continue traveling internationally to meet other nurses and gain better understanding of how they practice. There is so much we can learn from each other, so much knowledge and love to share. I am honored to be a member of the Honor Society of Nursing, Sigma Theta Tau International (STTI). When I was inducted into STTI, I had no idea I would someday travel the world meeting nurses and writing about them, an honor I do not take lightly.



It was the nurses!

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She wondered if the moment had finally arrived to tell the story.

Last month, I had the privilege and high honor of delivering the endnote address to hundreds of neonatal nurses who attended the 30th Annual Educational Conference of the National Association of Neonatal Nurses (NANN). Asked to speak on the topic of civility and healthy workplaces, my presentation was titled "Igniting the power and passion of civility in nursing: Creating healthy workplaces."

My objectives were to emphasize the imperative of fostering civility in nursing and provide several evidence-based, ready-to-use strategies for creating and sustaining healthy workplaces. The organizers of the conference asked that I deliver a message of optimism and highlight positive aspects of transforming practice environments, a request that fit easily and comfortably with my views on the topic. Clearly, the dedicated, hardworking nurses in attendance wished to end the conference and return to their busy, high-stress working places refreshed and invigorated by a message of hope and inspiration. I was determined to do just that, because they deserved my best.

What the organizers didn't know—and what I chose not to disclose until the day of the event—is that, just over 30 years ago, I was the mother of a high-risk infant, a baby who spent nearly two months in a neonatal intensive care unit. Conceived during a northern Illinois winter, known for its frigid, tundra-like conditions, my firstborn child was due to be delivered in early August, associated in our hemisphere with sunny summer days. Who knew, instead, he would enter the world in the spring, almost 10 weeks before his due date?

Eric's story is one I had never shared outside our family and close circle of friends, and, as I prepared for the NANN conference, I wondered if the moment had finally arrived to share a small piece of Eric's early beginnings. There would likely never be a more fitting audience than this group of exceptional neonatal nurses, so, with Eric's permission, I closed my endnote address by sharing this story. After all, had it not been for the unwavering, exceptional care provided by the entire NICU team, especially the nurses, Eric might not be with us today. One of NANN's core values is advocating for quality patient and family care. Eric's neonatal nursing team took this value very seriously and lived it—every minute of every day.

I was young and inexperienced. I read just about everything I could on the topic of pregnancy, and talked with my mother and grandmother frequently about my pregnancy and pending delivery. Like most young mothers, I was thrilled and a bit fearful—all at the same time. Most of my pregnancy progressed normally, but long before the due date, I began to feel sluggish and nauseated. I became quite edematous and easily fatigued. I kept thinking something was wrong, so I visited my physician, who assured me I was fine. Somehow, I knew that wasn't true, but I forced my worries to the back of my mind and allowed myself to think only about delivering a healthy child. In my way of thinking, if I thought it, it would happen.

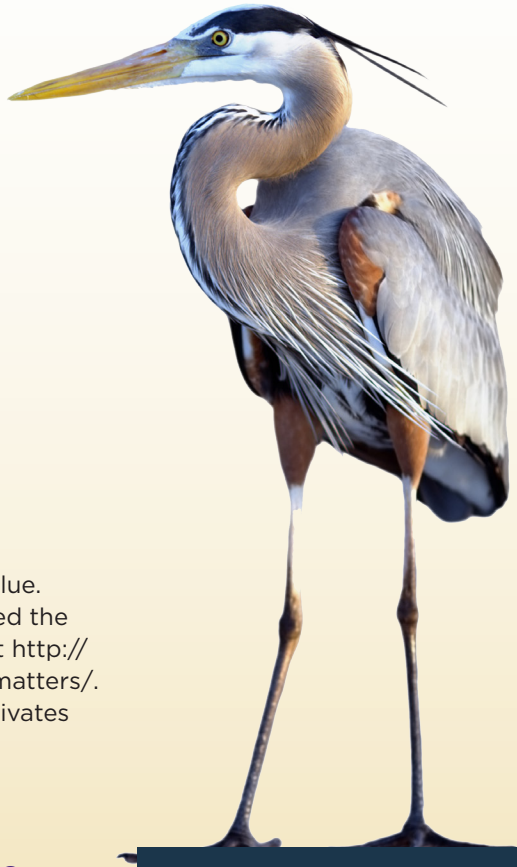
When it became evident Eric would be coming much too early, I was rushed—following a flurry of examinations and ER visits—to a nearby medical center that boasted an excellent neonatal intensive care center. I remember arriving terrified. Immediately, I was swarmed by members of the medical team, all of them trying to determine the best course of action. Tests were run, examinations completed, and consultations made, all in a hurried attempt to save Eric's life. Specialists agreed that the only chance Eric had of surviving was to prepare me for vaginal delivery.

Tests had determined that Eric suffered from a rare condition that included an in utero bowel perforation, an enlarged liver, and gross abdominal ascites, so we knew going into the delivery room that the odds for his survival were poor. The delivery room was packed with nurses, physicians, medical students, respiratory therapists, and just about anyone else who might be needed to save our baby's life. The delivery itself was excruciating, and the level of infection I incurred post-delivery kept me hospitalized for nearly two weeks. But the real story is about Eric. A tiny, vulnerable infant, his Apgar score was 1, but only because he had a weak and thready pulse.

He was rushed to the OR, where surgeons fought to save his life, conducting a procedure so revolutionary it had only been performed twice before. Chances of Eric's survival were grim, particularly when, six days later, his bowel reperforated in another area of the colon. Over the course of the next 10 weeks, I experienced a roller coaster of emotions—fear, hope, worry, and yes, a love so deep it is unexplainable—all juxtaposed, layer upon layer. Through it all, the nurses—yes, those glorious, wonderful, highly skilled nurses—took care of every one of us, not just Eric, while our devoted family and friends stood vigil, hoping and praying for Eric's health and recovery.

It was the nurses who, day in and day out, held my hand, accepted my tears, and encouraged me to never give up hope. It was the nurses who loved my son nearly as much as I did and inspired me with stories of other babies who had graduated from the NICU and were living healthy lives. It was the nurses who gave me hope, who never grew tired of my need to talk, who found a way to help me through every second, minute, and hour of each challenging and exhausting day. And finally, it was the nurses who helped me prepare for that most glorious of days—taking our son home. I have never forgotten, nor will I ever forget, the kindness, caring, and dedication shown to our son, our entire family, and me. Because of the nurses, our son is alive today and leading an incredible life. Though he has some physical limitations and lasting deficits, none of them has affected Eric's beautiful and brilliant mind. He has earned a master's degree in civil engineering and works as a professional environmental engineer. He is funny, witty, highly intelligent, and an incredible role model, not only for his two younger sisters but for all who have the privilege of knowing him.

I told this story to the audience of neonatal nurses at the NANN conference for the sole purpose of expressing my deepest gratitude for the tireless and important work they do every day. I shared the photos included in this blog to illustrate the incredible life that Eric now leads largely because of their efforts.



Cindy blogs at http://musingofthegreatblue.blogspot.com/ and created the Civility Matters website at http://hs.boisestate.edu/civilitymatters/. The great blue heron motivates and inspires her.

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