JOURNAL OF NURSING

Jocularity!™

THE HUMOR MAGAZINE FOR NURSES

Talking with Loretta LaRoche

SPECIAL Humor In The Classroom

Dear Nurse Marge

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Welcome
to the Journal of Nursing Jocularity
Again!

Publisher – Karyn Buxman, RN, MSN

In the words of our founder, our hope is to allow nurses the opportunity to laugh at this very worthwhile, but sometimes overwhelming and thankless professional we all share. Since the days we first started JNJ, tremendous amounts of research has been done, and now we know what we've always believed: humor really is the best medicine! Finding laughs where we can makes us better nurses and happier people.

The JNJ has two purposes. The first is to share the best funny material we can find. The second is to focus on the concept of humor itself, so we can understand why humor works and how to best bring laughs into work to help our patients and ourselves. From cutting edge research to 'how to train your doctor!', you'll find it all here. We're devoted to finding the best possible resources and presenting them to you, each and every month!

Our History

Some of you may be thinking that you've seen the Journal of Nursing Jocularity before. You're right! I was Vice-President of the JNJ during its eight year stint and best friends with publisher, Doug Fletcher. Doug had a great vision when he created the JNJ and left a tremendous legacy. His untimely death in an auto accident, along with the deaths of our friends and colleagues Bob Diskin, Georgia Moss, and Diane Rumsey, left a huge void in the world of healthcare humor. In Doug's honor, AATH has named its Lifetime Achievement Award after Doug.

Below is an announcement I created when we ceased publication of the JNJ. Barely a day goes by that I don't think of Doug and smile.

Journal of Nursing Jocularity was a quarterly publication for nurses and health professionals that was written, edited, illustrated and published by nurses and health professionals. The first issue was Spring, 1991; the last issue was the Spring, 1998. Filled with satire, true stories, cartoons, and all around funny stuff related to nursing and health care – it established its place in nursing history as the only humor magazine for nurses.

We've taken time; to heal, to grow, to learn. And in that time, we've become even more committed to the therapeutic value of humor. Nursing, as a profession, is under more stress than ever before. We're being asked to do more, with less, as hours are cut and benefits evaporate. The ability to laugh has become essential, for our patients, and for our selves.

So we're back -- and ready to ROCK! If this is your first time reading The Journal of Nursing Jocularity, welcome aboard. And if you've read us before, we're glad to be back with you! You can also find us online at www.journalofnursingjocularity.com -- your source for nursing humor, celebrity interviews, insights on the application of therapeutic humor and laugh out loud jokes and cartoons!

JNJ

"We've taken time; to heal, to grow, to learn."

Doug Fletcher
Doug had a great vision when he created the JNJ and left a tremendous legacy.

JNJ Talks to...

Loretta LaRoche

Internationally renowned humorist and stress management expert, Loretta LaRoche is familiar to many of us who adore her PBS specials, read her weekly column, 'Get a Life', and hope to conquer stress in our workplace. We were thrilled and honored when Loretta agreed to sit down with the JNJ team for a chat.

JNJ: Loretta, you're really famous for your work on stress management. Our readers are nurses — and being a nurse is pretty stressful. What would you have to say to nurses?

Loretta: *I love nurses. In fact, I dedicated my first book to nurses. It's called* "Relax: You May Only Have a Few Minutes Left".

Really the best tool that nurses — or anybody! — could have is positive psychology. This is a new field of psychology, there's a plethora of researchers working on this right now, delving into how it works and why it works.

With positive psychology, you focus on your strengths. You keep that focus, even when you're stressed. With most people, well, most people tend to skew toward the worst. That's how they wind up in this total black hole of despair: by focusing on how bad things are, how horrible everyone is, how things are never going to get better. It's called 'catastrophizing'.

JNJ: So what's the alternative to catastrophizing?

Loretta: *You have to learn to find the 'bless in the mess'. Positive psychology enables us to get through life in a strong way, rather than focusing on the weakness.*

Think about the impact this has in the workplace. When we work with other people, as most nurses do, there's a tendency to hook up and share the things that aren't working. This sharing actually increases the stress — I call this practice suffering!

JNJ: Given the demographics of the typical nurse — many of whom are female, many of whom are Boomers, who are faced with dwindling resources and yet are part of this 'sandwich' generation, with parents, kids, and grandkids to worry about: how do we bless this mess?

Loretta: *Everything we do involves a choice. If you find yourself in a situation you can't fix, where you're getting sick, and you see that stress response growing day by day by day, you have to ask why you're not looking for other options? At some point, we are all going to exit this life. Why make the journey suffering?*

If you're suffering, you're not gong to be able to do what you need to do. You're certainly not going to do it well.

JNJ: Now, humor can be a great tool to address and alleviate some of that suffering.

Loretta: *Absolutely! Stress can be a rich resource for humor. Most medical people have a great sense of humor. The entire show MASH was predicated on that concept. Humor is inherent in many dark situations.*

JNJ: So where do we go wrong?

Loretta: *I think in part, it's because women are socialized to complain. We get together and we talk about how bad things are. When was the last time you heard one guy walk up to another guy and say, "You know George, I'm really bloated." They just don't do that. It's not their nature.*

But when we bring that complaining behavior into a care taking setting, you're making yourself weaker. I'm a big proponent of manifesting energy; and how the words we use affect the way we feel. If you constantly use negative dialog, you're going to suck the life right out of yourself.

I'm continually shocked that more hospitals don't offer training in the Optimistic Explanatory style. That's one of the precepts of Positive Psychology that would help tremendously.

JNJ: Can you offer us some tips or insights in how we could start using this concept on an everyday basis?

Loretta: *You can begin by learning to be more inclusive. Be open to what's going right instead of dismissing everything that's wrong. Concentrate and focus your attention on what's going right. What are you doing that feels good? What are other people doing that's good?*

Don't just keep this to yourself. Go up to someone else and say "Good job! The way you handled that? That was great!"

JNJ: This reminds me of the advice we often hear to start each day with thoughts of gratitude.

Loretta: *Absolutely. Wake up, look around, and say, "Look at this! I'm back!" If someone's in bed next to you, you can say, "Hey, it looks like you came back too!"*

It's another good day, if I'm breathing.

Of course, this takes more effort than you might realize. Feeling good is not something we're used to. Not surprising when you consider 75% of all conversations are negative. We have to begin by changing the conversation!

JNJ: So this is a sort of proactive reframing exercise?

Loretta: *Absolutely. You can say "Look how many patients I made comfortable today" rather than dwelling on how overloaded you are or how many nurses called in for that shift.*

You can be proactive about the atmosphere you work in, too: making positive changes to improve things for everyone. I know that's hard: some people are in environments where change doesn't come easily. But I'm one to say you've got to keep trying. Keep trying! You're here to make a difference.

JNJ

"...be proactive about the atmosphere you work in, too: making positive changes to improve things for everyone."

Bedside Manners

by Dr. Patricia Raymond, MD, FACP, FACG

Family Matters...

Several years ago, I took an Adventure Women trip down the Grand Canyon, with thirty wild women in two inflatable rafts venturing down the Colorado River rapids to Lake Powell, over the course of five days. The trip of a lifetime.

I can not do justice in my description of the majesty of the view of the canyon from its base. As we traveled down river, the canyon walls progressively rose to either side of us, layer by layer. At night, we slept on the sandy riverbank, a narrow swath of stars visible in the slender night sky above, bracketed by the massive rock canyon walls.

As will happen in adventure travel, ladies got injuries from scrambling down side canyons on hikes. A twisted ankle here, a scraped knee there. As I had been outed as the sole physician on the trip ("Hey, I just do butts" didn't keep the limbs away), I got to make hmmm noises as I prodded swollen ankles looking for crepitance, and then sent the injured to soak their ankles in the frigid river.

Thank goodness for the three nurses taking the trip. After one askance look at my attempts to use an ace wrap, they graciously took on the practical aspects of the management of our patients, so the patients no longer resembled extras from "The Mummy Walks". I was glad for my medical family and for their skill set.

Around suppertime midway through the journey, the swamper (the all-purpose cook/cleaner on the trip) called me over to see a new patient, Joan. Joan's traveling companion had notified the raft crew that she wasn't feeling well at all.

When I spoke to Joan, it was clear that she wasn't well. Disoriented, weak, and confused, her breath wafted over my face. Fruity. A quick search of her belongings by my (medical) family revealed that Joan had the gear for diabetes. A friend on the trip revealed that Joan had at times referred to herself as 'brittle', and had been disturbed by the irregularities of the meal times and contents during our rafting. I was aghast. What was a brittle diabetic doing on a trip of this sort?

However, no time for aghast. Our patient was in DKA, mid canyon. No help available. My medical team unearthed Joan's glucometer, and we started administering the regular insulin we had found, using readings of blood glucose to assist in our guesstimates. Although she was confused, my colleagues encouraged Joan to drink an electrolyte solution we had concocted from fruit juice and salt. Her pulse was rapid and a bit weak. We felt desperate and a bit alone, with those towering walls, night falling, and no advanced medical assistance.

As darkness fell, I noticed the swamper fiddling with some equipment from the raft—a short wave radio. But once set up, he didn't use it to call out; he simply sat, gazing at the sky. Suddenly he picked up the handheld and called out.

"Mayday mayday, mayday. Mayday mayday, mayday from the canyon. Mayday mayday, mayday."

A response came. "Canyon, this is United 2657 en route to Las Vegas. What is your situation?"

Not so alone after all. It turns out that planes monitor the airwaves directly over the canyon as they pass. We lost United in just a few moments, but each plane that left our airspace (we could see their lights travel through the thin patch of stars overhead while in radio contact) would tell us when the next plane would make contact. The tower relayed our calls to the local ED, who helped us to manage Joan through the night. Joan survived to be helicoptered out of the down river Bright Angel Camp the next day, complaining all the while that she felt fine. She did in fact do fine, due to the varied skill set of my medical family. My colleagues.

Family matters. But just as the American family structure has changed, so too has the medical family. Allow me to explain.

Davies, in a 1999 British Medical Journal article, described the Medical Family as it was in ages past. The doctor, a father figure, wise, firm, kindly, and in command of the family. The nurse, the mother figure, dutiful and watchful, caring for both the father and child. The patient, our child, respectful and obedient, and in awe of the father. Yeah right. You can stop your sniggering now.

The medical family in the past, and perhaps still in the minds of your older physician and nurse colleagues, was a clear vertical hierarchy. But what of the medical family today?

Today's medical family is no longer vertically arrayed, but horizontal. The physician is a partner in health care, providing advice and information which may not be heeded; the nurse, also a partner in care, seeks to calm the waters between the doctor who perceives a loss of control and the non-compliant patient; the patient, now partnered with us, seeks medical guidance but is autonomous in actions. It's a whole new ball game to those of us raised on Marcus Welby.

Central to improving your dysfunctional medical family is having all members understand this new horizontal array of family positions, that doctor, nurse, and patients in today's healthcare are partners, no longer subservient.

You must help your colleagues to understand. Think of it as an adventure.

JNJ

"What was a brittle diabetic doing on a trip of this sort?"

by Elizabeth A. Schultz, RN, BSN

Whinorrhea!

Marsha took a deep cleansing breath before entering Room 519. It was only midnight, and she already answered Mrs. Gorski's call light four times. The evening nurse had given Mrs. G. a Halcion at 9:30 and assured Marsha she would sleep through the night. Another empty promise.

"What took you so long?" Mrs. G whined. "I called 10 minutes ago. What if it had been an emergency? I could be dead by now..maybe that would be a good thing. I wish I were dead."

"Mrs. Gorski," Marsha said calmly, "I saw your light go on from down the hall. I finished what I was doing and came directly to your room. I've been in here five times, and I really do need to check my other patients before it gets much later. Now, what can I do for you?"

"Don't argue with me young lady! I just told you that I wish I were dead and all you want to do is defend yourself and call me a liar. Some nurse you are!" Mrs. G cast her eyes to the ceiling and batted them furiously as if fighting back tears.

"You wish you were dead, Mrs. Gorski?" Marsha reflected, using her therapeutic communication skills.

"That's what I said, isn't it?" Mrs. G. snapped.

"Would you like to tell me about it, Mrs. Gorski?"

"Well, I'm sure you don't really care, no one does, but I really need someone to listen to me for a change. All my life I just give, give, give to my family and friends and now, when I'm knocking on death's door, where are they? I'm living in pain and they just carry on as if nothing had changed. No one comes to see me. No one cares."

Again using therapeutic humor communication, Marsh attempted to explain that Mrs. G's surgery, an appendectomy, and emphasize the fact that her condition was not at all critical. She had suffered no complications and would be discharged in a day or tow. Marsha also pointed out that Mrs. G's husband visited every evening after work and her children stopped by or called every day as well. She asked Mrs. G what she thought about all the cards and flowers in her room.

"Guilt!" Mrs. G blurted. "Pure, unadulterated guilt. They're just going through the motions. I knew you wouldn't understand. And as for my condition, Miss Know-It-All, I know they're not telling me the truth. I'm sure I have cancer and that weasel I'm married to won't let them tell me."

Marsh acknowledged Mrs. G's obvious anxiety and encouraged her to discuss her fears with her doctor in the morning. Then Marsha offered to help her get settled for sleep.

"Sleep? I haven't slept in days. I can't get comfortable. These flowers give me a headache. My water is warm and tastes like plastic. This place is too noisy and those sleeping pills don't do a damn thing. I think they're giving me placebos. I'm sure you're dying to get out of here, so why don't you just run along? Your coffee's probably getting cold and you're missing out on all the juicy gossip at the nurses' station."

Marsha fluffed the pillows and straightened the covers. She placed her hand on Mrs. G's shoulder, looked into her eyes with her most compassionate gaze and said, "Good night, Mrs. Gorski. I hope you rest well." She wanted to take the call light away, but instead placed it well within Mrs. G's reach. "I'll be close by if you need me."

Does this sound familiar? Although Mrs. G's case may be a bit extreme, it is a classic example of an age-old condition that has only recently been named and understood physiologically. It is called whinorrhea and so far, two types have been identified: acute and chronic. Mrs. G obviously suffers from the latter. This is much more serious, and as of yet, essentially untreatable. This article focuses on recognizing and preventing acute whinorrhea.

JNJ CLASSIC

What is Whinorrhea?

In recent years, research pathologists have identified a gland, the whinalot, which is nestled between the intermediate and anterior lobes of the pituitary. Through increasingly sophisticated research technology, a new hormone, whinin, has been detected. Its composition is similar to that of ACTH but was not differentiated until 1981, when Dr. I. M. Smart discovered minute differences between the two. He traced its secretion to the tiny whinalot gland, which was previously believed to be a nonfunctional appendix to the anterior lobe of the pituitary.

In adults, the whinalot averages .013 x .01 x .005 cm in size and 5-6 gm. in weight. It is considerably larger in infants and peaks in size and production of whinin during puberty, then slowly shrinks in size and activity until age 25.

The whinalot is sensitive to the secretion of epinephrine. Sensitivity is generally decreased in the adult, so that only a prolonged secretion of moderate amounts of epinephrine will stimulate the production of whinin. When increased amounts of epinephrine are secreted, as in the "flight or fight" response, the whinalot is suppressed. But as the perception of an emergency subsides, and epinephrine decreases to a moderate level, the whinalot instantly kicks in, secreting large amounts of whinin.

Whining then travels to the area of the brain where emotions are controlled. It is most often neutralized by endorphins and no outward signs or symptoms are noted. But when it is not neutralized, symptoms of acute whinorrhea are seen.

Assessment of a Potential Whiner

Whinorrhea exhibits itself through incessant complaining in an annoying tone of voice, which frequently fluctuates in pitch. This elicits a negative response in the listener and obliterates all traces of sympathy. It serves no beneficial purpose to the sufferer and can slow recuperation in the already physically compromised hospital patient.

Patients are not the only sufferers of whinorrhea. It has been known to strike members of the health care team; usually because of relentless stress or by association. Although whinorrhea is not contagious, it has been noted to be somewhat 'catching'. Dealing with a whiner causes stress, increasing the nurse's susceptibility to whinorrhea.

Chronic whinorrhea is easily identified and can be noted immediately upon the patient's arrival to the floor or the ER. As stated before, it is essentially untreatable, unless the doctor will allow administration of high doses of tranquilizers.

Acute whinorrhea has a more insidious onset and usually does not show up until the patient has been hospitalized for at least 24 hours. Early identification of a potential whiner greatly increases the effectiveness of treatment. A few steps can be added to the nurse's admission assessment to help identify a potential whiner before he goes into full-blown whinorrhea.

Ask the patient if he feels that he experiences more than his share of bad luck. If he answers yes, you can be 90% sure you have a whiner on your hands. Negativity is a major contributing factor to whinorrhea.

Next, inflict a little pain and note the reaction. Sudden pain is known to cause instant and brief episodes of whinorrhea in those prone to the disease. Observer the patient while blood is being drawn or while you are starting his IV. If necessary, step on his toe or drop your clipboard on his shins. The pain test is a good assessment tool…use it.

Lastly, talk to the patient's family, if possible. They can usually tell you if the patient is prone to whining.

Treatment

Once Dr. Smart identified the whinalot gland and its function, the controversy over whether to treat whinorrhea began. Biochemist Dr. I. B. Smarter immediately set to work on a cure. He developed Anti-Whinin Factor (AWF), which prevents secretion of whinin. The AMA was not easily convinced that this was a condition that required intervention. Since doctors spend an average of five minutes per day with hospitalized patients, whining did not affect them. Nor did they realize the effect of whinorrhea on healing.

continued on page 8

Whinorrhea!

continued from page 7...

In 1988, nursing researcher Ima Angel did a comprehensive study of those effects. The following are a few of her conclusions: whiners take 150% longer to heal than non-whiners, use 100% to 200% more pain meds and are 5 times more likely to develop complications. These and other undisputed statistics spurred the AMA into approval. In November 1989, the FDA approved the use of AWF in the hospital setting.

Daily administration of intravenous AWF is highly effective, but therapy must begin before the whinalot begins secretion of whinin. This is why early detection of potential whiners is crucial. Patients are given a loading dose of 1 gram, then 500 mg/day during the course of their hospital stay. AWF not only inhibits the secretion of whinin but also increases production of endorphins.

Although it is a relatively safe drug, AWF is not without side effects. One percent of patients who receive AWF develop "Pollyanna Syndrome" and become constantly cheerful, compliant and completely unassertive. Also monitor your patient for hypotension, apathy, nausea/vomiting, vertigo and inappropriate or incessant laughter.

Chronic whiners like Mrs. Gorski will always be around, but studies show that only 20% of all cases are chronic. That means we now have the capability of effectively treating 80% of our whining patients. Nurses are taught to focus on the needs of the patient. Think how much more pleasant our jobs will be once AWF gains widespread acceptance. If your hospital is not using AWF, suggest it. It can save you and your patients hours of whining!!

JNJ

Bubblyography

Bubbly-ography connects our reader with the writers, artists, organizations, and others who help make the world a happier place. It's your one-stop humor shop for nurses!

The Gesundheit! Institute

Founded by Patch Adams, this site is a rich resource for educational opportunities, upcoming clown trips and the most up-to-date information on Patch's grassroots campaign: to put care back into healthcare. Check out the site for upcoming workshops and seminars on designing a new healthcare system: *http://www.patchadams.org/*

Patch Adams

Association for Applied and Therapeutic Humor (AATH)

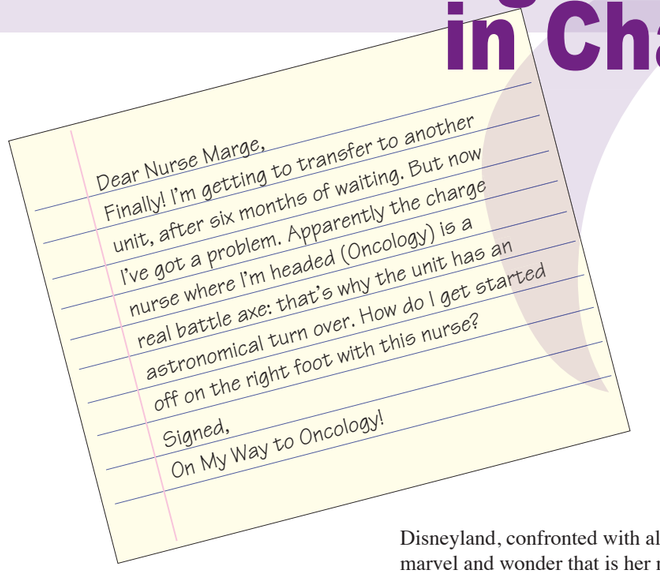
A nonprofit association comprising an international community of professionals who incorporate humor into their daily lives. The association provides a monthly newsletter and has an annual conference, approved for CEs for nurses. *www.aath.org*

World Laughter Tour

The World Laughter Tour is an international organization which provides training for the technique of "laughter clubs," which involves simulated laughter. This technique has been used in a variety of healthcare settings, for both care provider and patient.

Interpreting promising laughter theories and practices into multi-generational, multi-cultural health and happiness related programs; preventing hardening of the attitudes; providing methods that are uplifting, simple and powerful; making the world a better place; helping people make better health choices; providing the best value in training; for individuals, organizations, and service to the community. *www.worldlaughtertour.com*

Nurse Marge in Charge



Dear On My Way,
This is an easy question. When you get off the elevator, just look down at your feet. If you're about to step forward with the left foot, STOP AND SWITCH FEET.

Ok.

Maybe that's not the answer you're looking for. It's hard to work with a charge nurse who actively despises you, but it's impossible to make someone like you if you're not being genuine. Work place relationships require management, just like patients do.

What you want to do is remember the '8 -ates'. These strategies can help you handle even the crankiest charge nurse — or at least, make them leave you alone.

1. Hesitate stop and think before reacting to anything the Cranky Charge Nurse says. This will prevent you from saying the wrong thing at the wrong time. Also, if you hesitate long enough, she might get bored waiting for your response, and go away.

2. Dilate Dilate your pupils with wonder any time Cranky Charge Nurse says anything. Pretend you're a kid at Disneyland, confronted with all of the marvel and wonder that is her nursing prowess. This will either be found so endearing that you become the Cranky Charge Nurse's favorite or so annoying she avoids you at all costs.

3. Congratulate Knowing everything and directing everyone is a big job — and a big honor. Regularly congratulate your Cranky Charge Nurse on all of their accomplishments. Perhaps with a prize or cute trinket. Some people call this bribery. I call it workplace harmony.

4. Pontificate Nothing will interest a Cranky Charge Nurse MORE than hearing — in excruciating detail — every bit of medical research you've been reading in your off hours. Why, the developments in gastroenterology alone can make for HOURS of fascinating conversation. Make a point of sharing everything you've learned with the Cranky Charge Nurse, and she'll make a point out of avoiding you.

5. Congregate There's safety in numbers. Surround yourself with fellow nurses at all times. Never travel alone. A group must contain at least three nurses to deflect attention and appear truly 'busy'. With a little practice and coordination, you could even learn how to stage conveniently-timed codes…

6. Intimidate Cranky Charge Nurse can't scare YOU if YOU scare her! Consider hiring body guards. The economy's in the crapper, you could probably get some relatively cheaply. Judicious recruitment in the ER in the wee hours of Saturday morning may help you identify likely prospects.

7. Expectorate Ok, I admit it. This one's kind of gross. But if Cranky Charge Nurse makes you mad enough to spit nails, you might want to go with it. Or just imagine it: the mental image alone is worth it — and the resultant laugh makes it easier to put up with whatever she's yelling at you about now.

8. Regurgitate Every nurse pukes at least once. You know it, Cranky Charge Nurse knows it — heck, anyone who's watched more than three episodes of ER knows it! Luckily, these incidents are far and few between…but should one happen while Cranky Charge Nurse is nearby… Well, at least then, when Cranky Charge Nurse hates you? She'll have a reason.

Good Luck!
Nurse Marge

JNJ

From *Ha-Ha to a-HA!: Using Humor to Transform Nursing Education*
by Shirley K. Trout, PhD, Med

Humor in the Classroom:

Far More than Gimmicks!

I had to chuckle. A reviewer of an article I'd submitted challenged me, "Are twists cognitive challenges or educational gimmicks?" This question helped me realize that even those who understand the holistic value of humor in the classroom still have much work to do.

Humor used must have purpose

The reviewer's comment reminded me of the humor professional's responsibility to use humor purposefully. Humor should be used in ways that add value to the experience for the purpose of enhancing learning.

Rather than just eliciting a laugh for a laugh's sake, legitimate reasons to use humor so it facilitates enhanced and effective learning include:

- To break through communication barriers quickly and build community among learners.
- To get learners thinking "outside the box" so they can see their actions from the perspective of others in the community of care (e.g., patients, patients' families, physicians, case manager).
- To encourage higher-order thinking by applying their knowledge in an abstract context.

> **"Humor should be used in ways that add value to the experience for the purpose of enhancing learning."**

Be the Change

Busting through Social Barriers

Target Audience: Learners – any age

Purpose: To facilitate interpersonal communication within professional nursing context.

Supplies: Props *(puppets, stuffed animals, dolls)* and printed copies of group assignments *(one per chair)*.

Sample group assignments:

A. Your group represents a care team that will be serving a number of critically ill patients. You have decided that a mascot can quickly communicate your team's commitment to your patients and their families. After discussing the qualities each of you brings to this care team and what your team is committed to, do the following:

- Within the next 5 minutes, select a mascot (see props, provided).
- Write a "meaning statement," slogan or cheer that describes how this mascot will help guide your team.
- Prepare a 1-minute group presentation that will communicate the essence of your assignment.

B. Your group represents a care team that will be serving a number of orthopedic patients who require especially careful treatment during ambulation. You do not know each other well, but you have decided to use each other's strengths to assure the greatest comfort to every patient.

- Within the next 5 minutes, learn what each care team member has to bring to this team that will benefit the patients.
- Create some kind of physical representation that will help team members remember the strengths of each member and will help the team, as a whole, focus on the careful treatment of your patients and their families.
- Prepare a 1-minute group presentation that will communicate the essence of your assignment.

Time Required: Approximately 30 minutes.

Procedure:

- Before learners arrive, arrange chairs into groupings of 3 to 5; place a copy of the group's assignment on each chair.
- Place props in a location easy to access.
- As learners arrive, ask them to put book bags in a separate location and take a seat on one of the small-group chairs, read the instructions and get to work as soon as at least three members are in their groups.
- Allow 7-10 minutes for groups to complete their assignments.
- Allow up to 1 minute per group for group presentations.
- Allow up to 5 minutes for learning conversation that includes questions, such as:

∞ What was it like, from your perspective, when you first arrived today?
∞ Looking back on it, now, how would you describe the way you felt as you arrived compared to how you feel at this moment?

If learners indicate feelings of resistance then and displeasure now, then probe with requests for deeper understanding, such as: Talk more about that. Why do you think that is? etc.
∞ What do you know about your classmates now that you didn't when you walked into the room?

Don't expect students to have a great deal of insight at this point. This question is intended to begin the process of having them pay attention to others.
∞ Why did I have you do this activity?
∞ How does what I just asked you to do relate to you as a professional nurse?

Rationale:
- Nursing educators are being asked to focus learning experiences on quality of care and patient safety. These outcomes are impossible without effective communication among care team members.
- The humorous activity "diverts" the attention of the learners while getting teams to know each other quickly and focusing them on their role as health care professional.

JNJ

Cartoons!

by Dennis Fletcher

When I informed Mr. Thomas that his wife was critical, he said he was glad to hear Gladys was back to being her old self.

Sounds like the primary care physicians are having another meeting.

Back cover
Ad