Virginia Nurses Today

The Official Publication of the Virginia Nurses Foundation

May 2015 | *Quarterly publication direct mailed to approximately 102,000 Registered Nurses* | Volume 23 • No. 2

VNF VIRGINIA NURSES FOUNDATION

VNA VIRGINIA NURSES ASSOCIATION

We are pleased to provide every registered nurse in Virginia with a copy of Virginia Nurses Today. For more information on the benefits of membership in the Virginia Nurses Association, please visit www.virginianurses.com!

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Old Dominion University and James Madison University Receive Academic Progression Pilot Grants

The Virginia Action Coalition, a joint initiative of the Virginia Nurses Foundation and AARP Virginia, awarded two Academic Progression Pilot grants to Virginia universities partnering with local community colleges and hospitals. The grants are designed to make access to nursing baccalaureate education easier for registered nurses who wish to obtain a higher level of education.

"Research shows that nurses with a higher level of academic preparation help provide better outcomes for patients," said Shirley Gibson, Virginia Action Coalition co-lead. "We are pleased to fund programs that will help us achieve the Virginia Action Coalition goal of having 80% of nurses in Virginia educated at a bachelor's level or higher by 2020."

The first grant was awarded to Old Dominion University School of Nursing (ODU) in partnership with Riverside Health System (RHS) and Riverside School of Health Careers Professional Nursing Program (RSHC) for a program designed to allow students to obtain an associate of applied science (AAS) nursing degree at RSHC while concurrently enrolled in a bachelors of science in nursing program (BSN) at ODU. Coursework is blended throughout the program, and students will be able to complete requirements for both degrees at both schools within two years.

Additionally, grant monies will aid in transitioning the current RHSC nursing diploma program to an AAS degree-granting program. RHSC is currently the only remaining entry-level diploma-granting nursing program in Virginia and this transition will aid the success of the seamless academic progression model.

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Leadership Lessons from the Frontline

This is the first in a series of profiles of emerging nurse leaders. Terry Brosche, MSN, RN, CCRN, currently serves on the Virginia Board of Health and is the volunteer coordinator of the Virginia Action Coalition's Leadership Workgroup.

Terry Brosche, MSN, RN, CCRN

1. Tell us about your career as a nurse and describe your current leadership positions and associated duties.

My career began in the Intensive Care Unit at Hershey Medical Center as a staff nurse, charge nurse, and then clinical head nurse. When we moved to Virginia, my career continued in the ICU and, in addition to the staff nurse role, I became an educator for two schools of nursing, a peer reviewer for *Critical Care Nurse*, a poster presenter at several national conferences, and a legal nurse consultant. I also authored numerous articles, a series of online learning modules, and two books: *The EKG Handbook* (2010) and *Successful Online Learning: Managing The Online Learning Environment Efficiently And Effectively* (2011) I became a certified personal trainer and health coach in 1995, an AHA CPR, ACLS, and ACLS-EP instructor, and served on several community boards.

At the state and local level, I am actively involved with the Virginia Action Coalition leadership workgroup team and the Rappahannock Medical Reserve Corps, serving on the Public Health Response Team and the Mass Fatality Response Team. In December 2013, I was appointed by the Governor of Virginia to serve on the Virginia State Board of Health. In my roles as a board member and current chair of the nominating committee, we create policy and promulgate regulations that promote and protect the health of all Virginians in the Commonwealth.

2. What made you want to begin your journey to becoming a nursing leader?

Lessons continued on page 12

Staffing for Unique Pathogens: 2014 Ebola Crisis

Two Virginia heath systems share their stories and lessons learned

We sat down with Rick Carpenter, MSN, RN, Manager of the medical ICU at University of Virginia Health System and Audrey Roberson, MS, RN, CPAN, CNS-BC, Nurse Manager of the medical respiratory intensive care unit at VCU Medical Center to discuss responses to the 2014 Ebola crisis, specifically how staffing was affected, and the lessons learned for the future.

What was the first indication that your staff needed to become prepared for patients who had been possibly exposed to the Ebola virus?

Rick: We started looking at special pathogens, specifically MERS-CoV in May of 2014. Our small multidisciplinary team began planning at that point, but front-line caregivers were not trained at that point. It wasn't until August of 2014 that we started our preparedness planning and training to incorporate Ebola. Front-line team members started personal protective equipment (PPE) training in late August/early September.

Audrey: Recognizing the potential massive and complex care needs of patients/caregivers in West Africa, VCUMC proactively started having discussions regarding the potential admission of a Unique Pathogen patient in the Spring 2014, identifying key stakeholders who should be present and involved. During these discussions, it was decided that should a patient present to VCUMC with a possible Ebola exposure, these patients would be screened in our Emergency Department (ED) and then transported to the Medical Respiratory Intensive Care Unit (MRICU) for inpatient care. Specialized training with personal protective equipment (PPE) was initiated in the summer of 2014 for members from the MRICU team, which included RNs and Physicians.

Share your team's (and your facility's) preparation process and how it was similar or dissimilar to preparing for any other unique pathogen patients? What challenges did you face? What was easiest about the preparation process?

R: The biggest difference with the plan for special pathogens planning was the scope of training. With the emergence of Ebola virus disease (EVD) it was necessary to include many disciplines and services. these included our emergency management, infection control and prevention, hospital epidemiology, emergency department, medical icu, patient transfer center, bed coordination center, patient

Staffing continued on page 14

President's Message

Lauren Goodloe

I hope you had an enjoyable nurses week! I remain excited about this year's theme – "Ethical Practice. Quality Care." Our board and staff recognize the importance of ethics in nursing and acknowledge the strong commitment, compassion and care you display in your practice and profession. Nurses in all specialties and settings should make decisions based on a solid foundation of ethics, and this concept is so crucial that the American Nurses Association (ANA) has declared 2015 to be "The Year of Ethics." ANA released a new code of ethics for nurses and resources this year available exclusively to members. For more information, visit **nursingworld.org**.

The nursing profession has a long and distinguished history of concern for the sick, injured, and vulnerable, and for social justice. As nurses, we play an essential role in prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health in the care of individuals, families, groups, and communities.* *For the 13th consecutive year, the Gallup survey ranked nurses as the top profession for honesty and ethical standards.* As more consumers gain access to health care, they find that they are able to increasingly rely on nurses to provide important healthcare services. We must treat this faith our patients have in us with care and remember that our primary commitment is to our patients, whether an individual, family, or community.

To fulfill this contract between you and your patients, remember these four primary obligations** you must meet:

- Respect your patient's privacy and protect confidentiality,
- Communicate honestly about all aspects of your patient's diagnosis, treatment, and prognosis,
- Conduct an ethically valid process of informed consent, and
- Advocate for your patient's expressed interests or best interests.

We believe that you will be the best advocate for your patients when you are empowered to help create a positive work environment. Empowered nurses embrace today's professional challenges while remaining committed to ethical practice and quality care. To facilitate this, we've revamped and revised our *Workplace Advocacy Guide* for 2015. Our brand-new edition contains resources essential to your professional practice. In addition to chapters on advocacy, safety, and health in the workplace, *it also covers your rights and responsibilities as a practicing nurse and focuses on professional ethical issues.* Designed to fit in your pocket, this guide is a key resource for nurse empowerment and a useful, hands-on reference for empowerment. For more information, visit **bit.ly/vnawag** today!

I encourage you to renew your commitment to ethical practice and quality care this year. Please reach out to me at vnapresident@virginianurses.com and let us know how VNA can best serve you and your fellow nurses. Have a fun, safe, and healthy summer!

Virginia Nurses Today

is the official publication of the Virginia Nurses Foundation: 6912 Three Chopt Road, Suite H, Richmond, Virginia 23226, a constituent member of the American Nurses Association.
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Virginia Nurses Today reserves the right to edit all materials to its style and space requirements and to clarify presentations.

VNF Mission Statement
The mission of VNF is to continue programs of support and innovation for nurses and nursing in the Commonwealth.

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Virginia Nurses Today is published quarterly every February, May, August and November by the Arthur L. Davis Publishing Agency, Inc.
Copyright © 2012, ISSN #1084-4740
Subscriber rates are available, 804-282-1808.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613. (800) 626-4081, sales@aldpub.com.

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www.VirginiaNurses.com

Published by:
Arthur L. Davis Publishing Agency, Inc.

CEO Report

Janet Wall

VNA's Growing Education Calendar

I'm a habitual planner. Whether I'm adding dates of all 2015 art museum exhibits to my calendar, drafting my personal two-year strategic plan, or creating a timeframe for accomplishing work projects, it helps me to make sure I'm not missing a host of great experiences. Please join me in a bit of planning as we pin down dates and content for a growing calendar of educational opportunities. Work on each of these education events is ongoing, so please be sure to check back frequently at virginianurses.com to learn more and see what else we have in the pipeline!

September"-ish" 2015
Incivility in the Workplace Conference
Location: Multiple sites throughout VA

We're planning our first half-day distance learning event, which will have one live location and multiple satellite locations around the Commonwealth, in order to bring our events to your door. The program will be streamed to the satellite locations where attendees will be able to view the program and interact with the speaker(s) via live Q&A.

November 20-21, 2015
Fall Conference & Gala
An Interprofessional Focus on Patient- & Family-Centered Care
Hilton Short Pump / Richmond

For the first time, we will be inviting other healthcare professionals to join us during our conference to ensure even more robust breakouts and concurrent sessions to elevate our discussions about patient- and family-centered care. We anticipate many more "name" speakers, attendees, and poster presenters.

Plus, we're moving from downtown Richmond to the Short Pump area of Richmond (for both this year's conference and next year's), where you will find that overnight room rates are discounted, but quality is assuredly not!

February 16
Annual Legislative Day
Richmond Marriott / a quick walk from the state Capitol & General Assembly Building

April 29
Spring Conference
The Place at Innsbrook (Glen Allen / Richmond)

We held our first annual Spring Conference in early April; a great event and very well-received by the nearly 150 attendees who joined us to learning about successful staffing models and best practices focused on everything from the reduction of interruptions to staffing for unique pathogens (see page 1). We haven't yet started the planning for the 2016 Conference, but are eager to build upon the successes of our 1st Spring Conference!

September 23-24
Fall Conference
Hilton Short Pump / Richmond

Many of you indicated in a past survey we conducted that you would like to have more learning opportunities focused on mental health in the community. We think this is a great idea, and are eager to hear more from you about what this conference would like, including content and speaker ideas. Please share your thoughts at https://www.surveymonkey.com/s/7RPTTX9, to help us build the foundation for another excellent educational offering.

40 Under 40 Awards

The Virginia Nurses Foundation seeks nominations for our 2015 40 Under 40 awards. These awards These awards recognize 40 rising registered nurse leaders Virginia under the age of 40.

Qualifications
Nominees must:

- be no older than 39 by December 31, 2015.
- hold a current valid nursing license.
- Currently reside and practice in the state of Virginia.
- not be a previous *40 Under 40* award recipient. Previous nominees who did not receive the award are eligible.

Nominees should be willing to participate in a leadership development program which will include board leadership development training, mentorship and networking, as well as opportunities for engagement in the work of the Virginia Action Coalition.

Award Criteria
Nominees should have demonstrable achievements in the following areas.

Professional Practice
Significantly or uniquely contributes to leadership within the nursing profession through clinical practice, education/teaching, administrative leadership, research, writing, publishing, policy involvement, and/or healthcare innovation.

Leadership
Demonstrates leadership in the practice setting, community affairs, and/or nursing professional organizations, and in growth and development of others in these areas.

Impact
Positively promotes and advances the nursing profession beyond the practice setting, including but not limited to: presenting a positive image of nursing to their community (local/global), volunteerism/ outreach efforts, and/or legislative work/policy development.

Deadlines
Nominations must be submitted online no later than 5 pm on **July 31, 2015**.
Winners and their direct supervisors will be notified no later than by **August 31, 2015**.
Awards will be presented at the Virginia Nurses Foundation Gala on **November 21, 2015**.

Nomination Requirements
Nominations should be submitted in complete form. We cannot accept incomplete submissions.

Narrative - Nominators must submit a narrative describing why the nominee should be considered an outstanding young nurse leader. Narratives should illustrate achievements related to the three criteria explained above: Professional Practice, Leadership, Impact. We welcome specific examples of what makes nominees outstanding. (750 word maximum)

Letter of Recommendation - One letter of recommendation must be included. This letter should NOT be written by the nominator. Instead, we recommend this letter be written by someone who can contribute to the full picture of how the nominee fits our award criteria. This could be a supervisor, colleague, or someone outside the nominee's work setting. If more than one person wishes to submit a letter of recommendation, we recommend they work together on one letter. We cannot accept more than one recommendation per nominee due to the volume of applications we receive. (One page maximum)

Nominee's current resume or CV
To submit a nomination, please visit **http://tinyurl.com/VNF40under40**

2015 Fall Conference Call for Posters

Have you completed or planned a performance improvement, evidence-based practice, or research project?

Share your work with nursing and other interprofessional healthcare colleagues from around Virginia at our 2015 Fall Conference on November 21! **Accepted presenters will receive a 30% discount on conference registration fees!**

Awards will be given at the conclusion of the conference to the outstanding posters as determined by judges.

New this year! In addition to poster presentations from registered nurses, *we welcome submissions from other healthcare professionals.* Our committee encourages posters related to our conference theme – **An Interprofessional Approach to Patient-centered Care.**

Submit your abstract here: http://tinyurl.com/VNAposters2015

Important Dates

September 15 – Abstracts due to Selection Committee

September 30 – Accepted poster presenters notified (At least one presenter must attend the conference with an accepted poster.)

TBD – Conference registration closes

Please note that posters cannot exceed 4' x 4' in size. If your poster is already completed and does not meet these size requirements, please email Kristin Jimison at kjimison@virginianurses.com to discuss a size exception.

Save the Date!

VNA Fall Conference –
An Interprofessional Approach to Patient-Centered Care
November 20-21, 2015
(New date for 2015!)
Join us as we share diverse interprofessional perspectives on the important topic of patient-centered care.

The Hilton Short Pump
12042 W. Broad St.
Richmond, VA 23233

Virginia Nurses Foundation Annual Gala

VNF VIRGINIA NURSES FOUNDATION

November 21, 2015
Hilton Short Pump
Richmond, VA

VNA 40

Join us as we honor outstanding Virginia nurses with our "40 Under 40" recognition, as well as those individuals who have been supporters of the nursing community. We're also continuing to expand our very successful silent auction and raffle in 2015!

More information about the awards program, contributing items to our silent auction and raffle, sponsorships, ticket purchases, will be available online at http://tinyurl.com/VNFGALA15

ANA News

Conscientious Objection

When care collides with nurses' morals, ethics

Last winter, two high-profile — and very tragic — cases pitted family members against hospital administrations and stirred debates nationwide about brain death, policies and laws, and ethics. No matter where they practice, nurses may have wondered what they would do if they found themselves in similar circumstances — whether they could object to providing patient care. The answer is a qualified "yes."

First, the two cases

According to published reports, Jahi McMath, 13, was admitted into a California children's hospital for surgical procedures to address sleep apnea. Following surgery, she developed a complication, went into cardiac arrest, and was declared brain dead by two hospital-associated physicians and ultimately a court-ordered physician. Her family fought to have her remain on a ventilator until she could be transferred to an undisclosed facility where she could be given additional "life-sustaining" measures.

Marlise Munoz was 14 weeks pregnant when she was found unconscious at home. She was declared brain dead and carrying a nonviable fetus; her family wanted her taken off life support, noting her wishes, the media reported. But this time, the hospital where she was admitted objected — citing a Texas law it believed required them to keep her on life support until her fetus could be delivered. Again, a legal battle ensued. A judge ultimately ruled that the hospital was misapplying the law, and the hospital removed her from life support.

Members of the American Nurses Association (ANA) Ethics and Human Rights Advisory Board were not aware whether RNs objected to providing care in these specific cases. However, nurse ethicists did find it crucial to ensure that all RNs understand that they can conscientiously object to participating in interventions if certain criteria are met.

Confronting difficult decisions

Nurse ethicist Anita Catlin, DNSc, FNP, FAAN, followed the Munoz case in the national press.

"Nurses have a right to conscientiously object to participate in technologically supported treatment of a brain-dead person," shared Catlin, a member of ANA's ethics advisory board. "Additionally, when a woman and her surrogate have made their wishes known, it is unethical to go against these wishes as stated in ANA's *Code of Ethics for Nurses with Interpretive Statements.*

"If members of the nursing staff wished to be excused from participating in this patient's care for anything other than palliative care and comfort measures, they have every right to do so."

When it comes to nursing practice, there are two broad categories in which RNs can conscientiously object to participate — based on provisions addressed in the *Code of Ethics*, according to Marsha Fowler, PhD, MS, MDiv, RN, FAAN, a member of the ANA's professional issues panel steering committee, which has been leading a revision of the Code.

Nurses can refuse to participate in all instances of an intervention — such as an abortion or sexual reassignment surgery — based on religious or moral grounds, said Fowler, an ANA\California member. RNs who hold these strong beliefs should make their objections to participate in these types of interventions or procedures known at the time of hiring, Fowler said.

"If that's not possible for some reason, the nurse should make her or his objection as timely as possible so the nurse manager can find a replacement," she said.

Vicki Lachman, PhD, MBE, APRN, FAAN, added that for nurses to ethically object to participating in an intervention, that intervention "must challenge their moral integrity — and not be based on false motivation. It really has to violate a deeply held conviction of what's right or wrong. A nurse might believe that the sanctity of life trumps all."

The Code does not allow nurses to refuse care based on prejudice, discrimination or dislike. For example, they can't refuse to take care of someone because the patient abuses alcohol or because the patient is homosexual, according to Lachman, chair of ANA's ethics advisory board.

To decrease the chances of having to object on moral or religious grounds, nurses ideally should practice in settings where they are less likely to be confronted with interventions — such as abortions, cardiac transplants or palliative sedation — that conflict with their beliefs, Lachman said.

The other broad category in which nurses can conscientiously object involves a specific intervention with a specific patient, Fowler said. A common example of this ethically sound objection is when a nurse is asked to participate in an intervention that goes against a patient's autonomy and expressed desires, as in the patient's not wanting a blood transfusion, antibiotics or other lifesaving measures.

Given the fast pace of technology and other advances, nurses may increasingly find themselves in ethically challenging situations, Lachman noted.

Additionally, many sensitive cases that might have been kept private in decades past are now being played out in the media, according to Fowler.

Parting words

To make a conscientious objection, Fowler said nurses should follow the lines of authority and the structures that are in place in their facilities. They also can contact their organization's ethics committee or patient ombudsman.

And they must be aware of an obligation not to abandon a patient.

"Once a nurse begins treating a patient, she or he is legally bound to care for that patient until another nurse is available to assume responsibility for the patient," Lachman said.

And although it may take courage to conscientiously object — particularly given some workplace cultures — not doing so can have dire consequences for the individual nurse and for the nursing profession.

"Most of the time, nurses just remain silent and do not make their objections known. They also worry that their decision will place a burden on colleagues by giving them more work," Lachman said. "If nurses cannot move away from these situations, it becomes intolerable. They experience moral distress, emotional and physical fatigue, and burnout. Therefore, organizations must provide nurses with the staffing necessary to maintain their moral integrity, and nurses need to participate only in patient care that is not morally compromising. "

Fowler added, "Nurses need to accommodate and support colleagues who conscientiously object and provide an environment that preserves professional integrity."

— Susan Trossman is the senior reporter for *The American Nurse.*

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ANA News

ANA Launches New Resources to Help Nurses Quit Smoking

New Tobacco Cessation Position Statement Advocates Participation of Pharmacies

The American Nurses Association (ANA) is encouraging registered nurses (RNs) to live tobacco-free lifestyles with the assistance of new resources designed to help nurses serve as health and wellness role models for patients, families and communities.

"Nurses provide high quality health care to patients, but may neglect their own self-care," said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. "While many nurses have heeded the warnings and quit smoking, some continue this unhealthy habit. Nurses know the dire consequences of smoking, which is why smoking cessation is so critical. We want all nurses to be tobacco free."

The resources, part of ANA's HealthyNurse™ initiative, include a new tobacco cessation website and a new tobacco cessation position statement. The website offers resources to help nurses quit using tobacco and guidance to help patients stop using tobacco products, including information on acquiring better habits, overcoming addiction and finding support services.

The position statement, Promoting Tobacco Cessation in Pharmacies, is targeted to RNs, advanced practice registered nurses (APRNs) and health care professionals employed in pharmacies. ANA believes pharmacies and drug stores must be invested in promoting public health. Consequently, ANA recommends all pharmacies and drug store retailers follow the lead of CVS Health in ending the sale of cigarettes and other tobacco products in their retail pharmacies.

"At CVS Health, we believe our combined efforts of eliminating the sale of cigarettes and tobacco products from CVS/pharmacy, and a devoted smoking cessation program through MinuteClinic and CVS/pharmacy, will help smokers wishing to become tobacco free on their path to better health," said Angela Patterson MS, FNP-BC, chief nurse practitioner officer, MinuteClinic, the retail medical clinic of CVS Health.

According to the Centers for Disease Control and Prevention (CDC), more than 18 percent of U.S. adults smoke cigarettes. Additionally, the CDC reports tobacco use in the U.S. is the largest cause of preventable death. ANA believes tobacco cessation is the single most important action individuals can take for their health.

To learn more about ANA's tobacco cessation initiative, visit the HealthyNurse™ website at nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/Tobacco-Cessation

2015 ANA Ethics Symposium

Advance Registration Deadline May 22!

June 4-5, 2015 | Sheraton Inner Harbor Hotel | Baltimore, MD

A robust ethical nursing practice directly impacts quality and safety and supports the triple aim of better care and better outcomes at lower cost. ANA's Ethics Symposium will provide you with specific, action-focused ideas to improve ethical practice in your workplace.

Explore ethical challenges from educational, clinical practice, and policy/leadership perspectives. Learn the most important elements of an ethical practice and how to implement "ethical watchfulness" into your daily work. Address important ethical dilemmas facing nurses today and hear from those who have acted on their beliefs. This interactive event is your opportunity to collaborate with some of the nation's most influential ethics experts to create a culture of ethical practice, build your ethical competencies and resilience, and strengthen the ethical foundation of nursing.

Visit http://tinyurl.com/ANAETHICS15

Top Five Reasons to Join VNA

1. Show commitment to your profession!

Membership in VNA makes a powerful statement about you. It shows employers, colleagues and patients your commitment to nursing. Membership identifies you as a nurse who is serious about the profession as well as purposeful about staying informed, educated and involved. Joining VNA gives you an immediate connection to other Virginia nurses, and a real sense of community. Members have opportunities for networking on the local level at chapter meetings and on the state level at our conferences throughout the year.

2. Two memberships for the price of one!

When you join VNA, you *also* become a member of the American Nurses Association. For one membership rate, you receive the membership benefits of both organizations! More importantly, you join with nurses across the country and here in Virginia, speaking with one strong voice on behalf of your profession and your patients.

3. Significant Discounts on Continuing Education!

We're creating new continuing education programs for nurses throughout the Commonwealth. We're also developing and launching new options for you to learn and access quality educational programming - *options that fit into your busy schedule.* This year, we're debuting our first web-based CE modules available on demand AND testing a live-stream distance-learning program. All of these new learning opportunities are in addition to our in-person conferences and chapter meetings.

Don't forget: *members receive a significant discount* on all continuing education opportunities and receive access to more than 60 free and discounted CE modules through ANA.

4. Stay informed!

Stay up to date the news and issues affecting nursing through our free, members only publications and members only website areas. Members receive exclusive access to interviews, evidence based research, and much more.

Here's a sampling of member publications:

- ***VNA Voice,*** our monthly e-news — a compilation of important statewide news, relevant articles, and the latest goings on at VNA, including our Nursing Newsmakers section.
- ***Virginia Nurses Today Members Only Edition*** — an expanded digital version of *Virginia Nurses Today* with content available only to our members.
- **Legislative e-blasts and *Member Newsflash*** — email briefs with up-to-the-minute news on our legislative activities and breaking news relevant to nurses.
- ***American Nurse Today*** — Monthly journal (six print/six electronic) featuring peer-reviewed clinical, practical, practice-oriented, career and personal editorial.
- ***The American Nurse*** — ANA's award-winning bi-monthly newspaper
- ***OJIN — The Online Journal of Issues in Nursing*** — Peer-reviewed, posted online three times a year
- ***ANA SmartBrief*** — Daily eNews briefings designed for nursing professionals, delivered to your email box
- ***Capitol Update*** — Monthly e-newsletter covering the status of nursing issues in Congress and the Agencies
- ***Nursing Insider*** — Weekly e-newsletter with ANA news, legislative updates and events
- ***Navigate Nursing* webinars** — webinars on current and emerging topics provided free or at significant savings to members. Recent topics have included safe patient handling, reducing staff turnover and increasing job satisfaction.

5. We advocate for nurses!

When it comes to advocating on behalf of nurses, VNA is the only organization that speaks for the 100,000+ nurses throughout Virginia. Our lobbyist, leadership, and members work passionately to educate our legislators and state policymakers on issues crucial to the advancement of the nursing profession. We update our members weekly during our legislative calls and send legislative e-blasts with breaking news during the legislative session.

More opportunities are now available for all nurses to become involved with public policy and advocacy in Virginia. Every February, we hold our Legislative Day, a day of interactive education focused on preparing nurses to be advocates for their profession. Members are encouraged to be a part of our grassroots *Legislative Visibility Initiative*, where groups of experienced nurses and student nurses greet legislators as they arrive for the day, meet with them, and observe relevant subcommittee meetings. If you're interested, but new to the legislative process, this is a great opportunity for you to "learn the ropes" of advocating for the nursing profession.

The bottom line: there's so much in it for you as a member of your professional association. Join VNA today and help us amplify the voice of nursing in Virginia! Visit http://bit.ly/joinvnatoday to become a member!

Electronic Nicotine Delivery System Use – Children and Teenagers

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Dear Colleague:

Thank you for being a key partner in our collective effort to ensure the health and well-being of children in Virginia. Regardless of clinical specialty, we each have an opportunity to impact children's health. Yesterday, the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration's (FDA) Center for Tobacco Products released a report in the April 17, 2015, Morbidity and Mortality Weekly Report (MMWR) highlighting data that indicated a tripling of e-cigarette use among middle and high school students from 2013 to 2014. This correspondence is an effort to bring to your attention the possible dangers of electronic nicotine delivery systems (ENDS) including electronic cigarettes (e-cigarettes), vapor pens, and similar products. Much of the information in this letter focuses on ENDS use in children and teenagers but is relevant for adults as well. I am hopeful that this information will assist you in your daily efforts to provide relevant information to your patients.

The information below provides additional information on:

- Prevalence of e-cigarette product use
- Health implications of ENDS use
- Possible poisoning dangers

Prevalence of ENDS

The journal *Nicotine & Tobacco Research* published a study on middle and high school students who have never smoked cigarettes but have used e-cigarettes. Researchers from the CDC, FDA and Georgia State University found that during 2011-2013, the number of youth in the U.S. who had never smoked but who used e-cigarettes increased threefold, from 79,000 to more than 263,000. The study showed that 43.9 % of those who had never smoked but used e-cigarettes had an intention to smoke conventional cigarettes compared with 21.5% of those who had never smoked and had not used e-cigarettes. The 2013 Virginia Youth Survey indicates that 1.1% of middle school students and 9.5% of high school students recently tried using tobacco from a hookah or waterpipe, dissolvable tobacco products or electronic cigarettes.

Health Implications of ENDS Use

No state or federal agency currently regulates the manufacturing of ENDS. Cigarettes, cigarette tobacco, roll-your-own tobacco and smokeless tobacco are currently subject to FDA's tobacco control authority. FDA is finalizing the rule to bring additional tobacco products such as e- cigarettes, hookahs and some or all cigars under that same authority. E-cigarette emissions are not harmless water vapor; the emissions can contain nicotine and other chemicals such as formaldehyde, propylene glycol, acetaldehyde, acrolein and tobacco-specific nitrosamines. As such, we recommend that children be protected from exposure to the emissions from e-cigarettes and all consumers of such products cautioned that they may be exposed to varying levels of nicotine or other chemicals and contaminants in these products.

Please also advise pregnant women to avoid using ENDS products. Nicotine negatively affects fetal development, specifically the central nervous and circulatory systems. We encourage you to discuss with your pregnant clients the potential consequences related to exposure to nicotine, in conventional or e-cigarettes, including:

- Miscarriage
- Low birth weight, which creates significant health challenges for their babies
- Negative impact to the unborn baby's blood flow, heart rate and breathing

Electronic Nicotine continued on page 10

Electronic Nicotine continued from page 9

- Sudden Infant Death Syndrome

The cumulative health impact on individuals of any age using multiple nicotine delivery products, such as traditional cigarettes and e-cigarettes, are unknown.

Poisoning Dangers

It is illegal for a minor to purchase or possess any tobacco product, nicotine vapor products or alternative nicotine products, and it is illegal to sell or distribute those products to minors (Virginia Code §18.2-371.2). The liquid used in vapor products, also known as e-liquid, comes in a variety of flavors that may be enticing to children, such as cherry, chocolate, gummy bear and bubblegum. Approximately 7,764 different flavors are available through e-cigarette websites and can be purchased in non-specialty stores, including gas stations and convenience stores.

Acute nicotine toxicity is a health concern for children and adults. Most of the e-liquid on the market contains nicotine; concentrations in packages can vary significantly. The nicotine level in most e-liquids ranges between 1.8% and 2.4% but can be as high as 10% in each vial. The estimated lethal dosage of nicotine is between 1 and 13 milligrams per kilogram of bodyweight. One teaspoon of an e-liquid with a nicotine concentration of 1.8 % could be fatal for a 200-pound person. For a child, exposure to even a small amount of e-liquid could be life threatening.

Nicotine exposure can occur through ingestion, inhalation or absorption through the skin or eyes. Children exposed to nicotine can experience vomiting, tachycardia, respiratory failure, ataxia, seizures, gastrointestinal disturbance, and death.

The CDC identified an increase in calls to poison control centers due to e-cigarette exposures nationally. E-cigarette exposure includes exposure to the device or to the nicotine liquid. From 2010-2014, most states experienced a 50% increase in calls regarding e-cigarette/e-liquid exposures to children less than six years old. Virginia Poison Control data between 2011 and 2014 also showed an increase in the number of similar calls. During that time, there were 132 calls related to liquid nicotine and e-cigarette exposures, and 48 % of those calls were due to exposures among children under the age of six.

Please help spread the message to call the poison control center immediately at 1-800-222-1222 when exposure to an ENDS product or liquid nicotine is suspected.

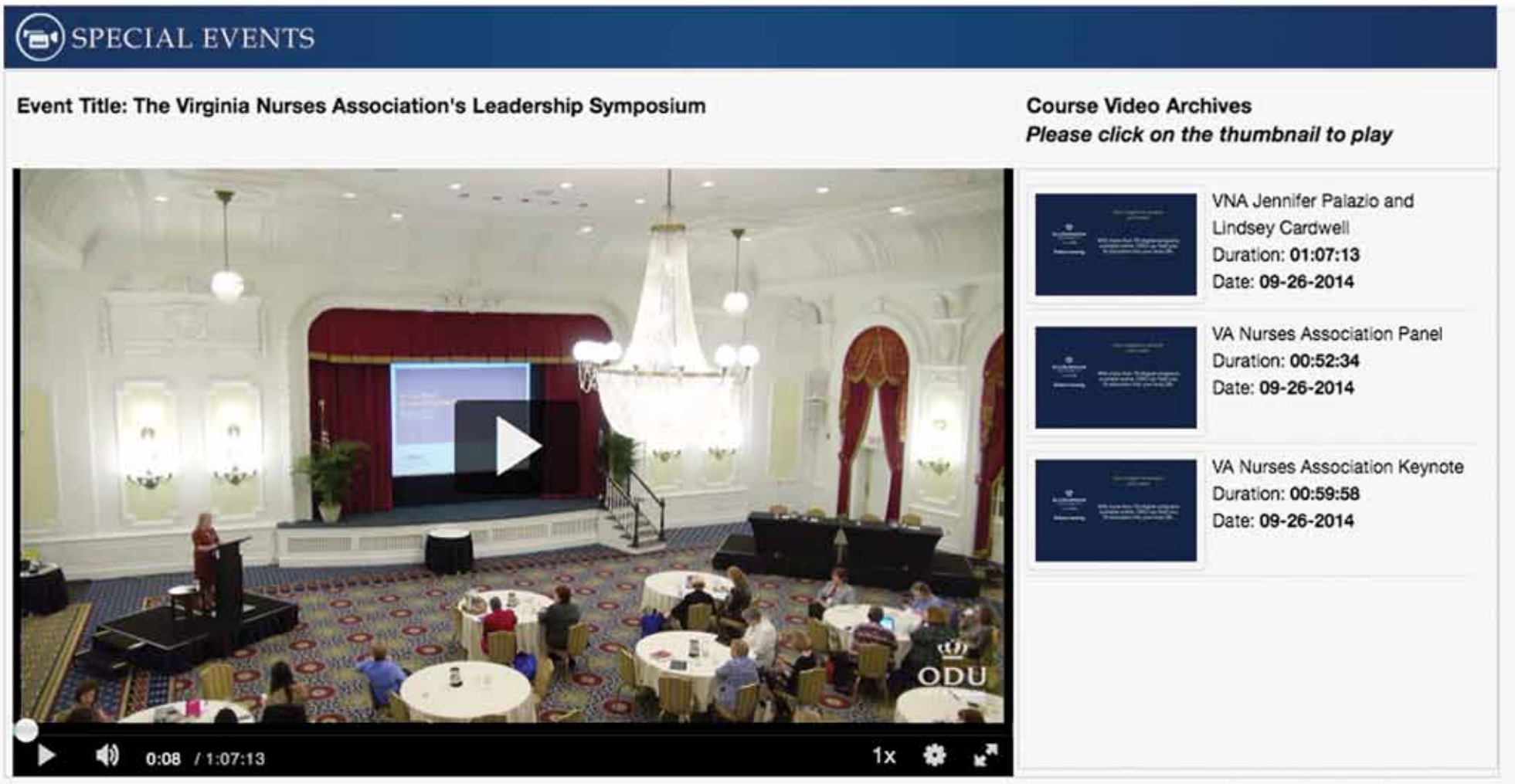
Current smokers often report using ENDS to help quit smoking. However, e-cigarettes and similar ENDS have not been adequately tested as tobacco cessation devices. VDH recommends FDA-approved nicotine replacement therapy products, which contain controlled doses of nicotine, to support tobacco cessation efforts.

Cessation support for traditional tobacco use as well as for ENDS is available free of charge through Quit Now Virginia. Quit Now Virginia is a toll-free tobacco cessation phone counseling service that is provided to Virginia residents aged 13 and older 24 hours a day, seven days a week. Callers may receive one-on-one cessation counseling, information and self-help materials. Quit Now Virginia can be contacted at 1-800-QUIT-NOW (1-800-784-8669).

Again, thank you for your help with this emerging health threat. I also appreciate your continued efforts to communicate to your patients the serious health consequences of all tobacco use and for your collaborative work to promote and protect the health of all people in Virginia with a special focus on our children.

A pdf version of this letter is available on the VDH Resources for Health Care Professionals web page.

NEW!
On Demand Leadership Continuing Education Program!



Bedside to Boardroom: Nurses Leading the Way Leadership Symposium

3.25 Contact Hours | $25 VNA Members | $40 Nonmembers

Nurses need leadership skills at all levels of the profession, from the nurse just beginning a leadership journey to the experienced nurse leader preparing for board membership. Our Leadership Symposium provides nurses with the knowledge, tools, and resources to develop and hone leadership skills and be an effective board member.

Presentations include:

Patient-Centered Leadership for Population Health Improvement
Steve Horan. PhD

Lessons from the Frontline
Kevin Shimp, MSN, RN, CCRN, CNML
Terry Brosche, MSN, BSN, RN, CCRN
Nancy Littlefield, DNP, MSHA, RN
Pat Conway-Morana, BSN, RN, NEA-BC

Giving Back: Nonprofit Boards Need You
Jennifer Palazio

Your Leadership Path
Lindsey Cardwell, MSN, RN

Instant access at http://tinyurl.com/VNACE

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I have always enjoyed taking on leadership roles; I find it to be very fulfilling to know that I am contributing to the nursing profession and making a positive difference in my community and in the lives of those whom I serve. I feel this was fostered as a child. My mother has been a nurse for 53 years and she has served in various leadership positions including head nurse, supervisor, and clinical director for a cardiology group, where she still works full time. She was the best role model and mother one could have and she demonstrated, and continues to demonstrate, what leadership entails i.e., dedication, fairness, honesty, humility, willingness to take a risk, and integrity. She helped to guide my path and I have embraced it fully!

3. Why do you feel it is important for nurses to develop leadership skills?

Nursing is at the frontline. We are the largest providers of healthcare and very involved with patients, communities, and outcomes. Our leadership and the ongoing development of our leadership skill-set is essential because this will lead to improved patient and community outcomes. In addition, it can improve our personal outcomes, including striving for and maintaining a balance between the body, mind, and spirit.

4. What is the biggest challenge facing nurses who wish to become leaders? What about board service?

Nursing leaders are wanted! Boards, committees, non-profit and for profit organizations recognize the value in having a nurse on the board. However, the biggest challenge for the nurse is in engaging in the process to identify what *seats* need to be filled and what *seat* best matches the passions of the nurse willing to serve. This can be a challenge because of the following: a) fear of the time commitment i.e., "I do not have the time" b) fear of failure i.e., "I may not be chosen to fill the position or the *seat*," c) fear of the unknown i.e., "I do not feel I possess the necessary skill sets to fill a certain *seat*," and d) fear that the position may misdirect the individual away from a path, that they *feel*, will get them from Point A to Point B.

These challenges are real and valid but it is important to remember that nurses are needed at the table! We have the knowledge, skills, and attitudes that can be a great asset to a board or an organization. Facing these fears is part of the path to personal excellence in leadership.

5. Tell us about your biggest success serving on a board.

At the end of my tenure as the President for the Board of the Greater Fredericksburg Habitat for Humanity, we built our first home. It was so fulfilling to see how the work that was done by the board, the volunteers, and the family led to the completion of Habitat for Humanity home. It was also fulfilling to see first hand how the team, although diverse in thoughts, values, beliefs, and opinions, worked so efficiently and effectively to reach a common goal.

6. Who has inspired you?

Throughout my career, I have been privileged to meet many people who have inspired me to grow personally and professionally. In nursing leadership, there have been several individuals whom I have admired for some time. The first is my mother. The second is Dr. Shirley Gibson. I have known Dr. Gibson for years, having first met her when she served as the Director of Nursing at a hospital where I was employed. I watched how she would engage with the nursing staff when she made rounds on the floors. I witnessed and heard how she would always advocate for nursing and for the patient. Her love for the nursing profession was apparent and it did not take me too long to realize she had the knowledge, skills, and experience that could assist me to further develop my leadership skills. This led to a mentor-mentee relationship that exists to this day. When I was appointed to my current board position she was the first one I called and she has been there throughout to advise, support, coach, and sometimes just lend an ear.

7. What advice do you give nurses who are interested in furthering their leadership skills?

- **Respond** with YES if asked to accept a leadership position that matches with your passions. There will never be a "right time" - the right time is the present time. Engaging in the process can help to further enhance understanding of what you know and what you need to know.
- **Identify** a mentor. Every board is not the same. Finding a mentor can assist in maneuvering through the process and can also assist in making the connection between the nurse and a leadership opportunity.
- **Read** everything and be a life-long learner. For example, when I was first appointed to the State Board of Health I read the orientation manual, the board minutes from the past 3 years, and the bios of the other board members. I also began reading the updated version of *Robert's*

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Rules and I signed up to receive daily information about what is being done at the local, state, and national level.

- **Engage**, get involved, and access the available resources. There are numerous tools and resources on the VNA website and, in fact, there is a leadership tool kit that can be found at http://virginianurses.com/Main-Menu-Category/Leadership-Development/Leadership-Toolkit. The VNA also holds a yearly leadership conference and many other educational seminars. The Robert Wood Johnson Future of Nursing website: http://www.thefutureofnursing.org/topics/leadership houses information, blogs, and videos about leadership. These resources, combined with involvement in the VNA, the Virginia Action Coalition workgroup teams, and other organizations can help to make the connections and gain additional knowledge.
- **Think** creatively. *Life begins at the end of your comfort zone.* Do not be afraid in proposing new ideas or new strategies, even if they seem a bit outside the norm or are outside of your comfort zone. This will help to avoid complacency and will also help to keep your organization up to date, in this continually changing healthcare environment.
- **Research** by observing and talking to the experts, along with those at the grassroots level. If you are not a board member, ask to sit in on board meetings to better understand the roles and functions of the board. If you are a board member, meet with the experts on topics that will be discussed or voted on and visit with the people you are leading or serving. In doing so you will gain first-hand knowledge and suggestions.

  It is important; however, not to go in with preconceived notions or with an agenda. Reflect on what is said and think about how you can use this feedback to make a change or make an informed decision. For example, in preparation for a statewide meeting I attended, I contacted a leading, national organization to gather additional information about the topics that would be discussed. The Executive Vice-President of the organization provided me with valuable insight, addressed questions I had, and offered helpful information that I was able to share with other stakeholders at the meeting.
- **Maintain** a balance between the body, mind, and spirit. It is harder to lead if there is an imbalance in the body, mind, and spirit. A spiritual leader suggested the following, "Create bookends for your day. Start the day with a prayer for strength and guidance. End the day with a prayer of contrition and reflection to assess how you could have been better in serving those around you. Then commit to the change."
- **Personal Code** requires knowing who you are and who you represent. I was listening to a radio talk show where the interviewer asked a legislator about how he prepares for sessions. The legislator said one of the most important things in leadership is to know oneself and one's own personal principles. He suggested that one should never violate these principles; however, it is important to remember to learn the art of compromise when appropriate. He also suggested to personally review these principles prior to going into each meeting. I now do the same and to assist in this process, I have the International Code of Ethics for Nurses taped to the binders I carry in to board meetings.
- **Thank** those who help you and those who work with you. Also take the time to thank yourself and recognize the knowledge, skills, and attitude you can bring to the table.
  - **Knowledge** examples: Our knowledge about the nursing process, the ISBAR reporting system, and therapeutic communication techniques.
  - **Skill** examples: Our skill in providing patient-centered care using evidence and clinical practice to support decisions, working in interdisciplinary teams, ongoing involvement in the quality improvement process, and incorporation of informatics.
  - **Attitude** examples: Our ability to recognize the complexity and diversity of individuals, patients, and our citizens, to address inefficiencies in work systems to ensure quality and safety, and our understanding that we need to balance all of this with cost.

Do you know an emerging nurse leader we should feature? Email Kristin Jimison at kjimison@virginianurses.com!

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relations, emergency medical services, medical transport network, employee health, student health, environmental services, telemedicine, and public relations.

Initially the biggest challenge was obtaining the necessary supplies, especially PPE, for training. We had a limited supply of material and needed to maintain a par level in the event we might receive a patient with EVD. Another challenge was training enough team members in a reasonable time frame. Because of the limited availability of PPE it was necessary to keep the team small, but include enough team members to manage care for an extended period of time.

In the beginning planning was also a challenge. For the most part none of us realized the amount of resources and time this would consume. It quickly became evident that this was a priority and required our undivided attention. This morphed into what soon became the easiest part of the preparation. The teamwork and dedication of team members from the health system was phenomenal and eventually made all of the pieces fall into place.

A: The team at VCUMC began this journey with multiple discussions with key departments that would be integral in the outcomes of these patients. This included Nursing and Physicians from the MRICU, pediatric ICU (PICU), neonatal ICU (NICU), labor and delivery (L & D) and the ED, epidemiology, emergency management, infectious disease, laboratory, radiology, employee health, respiratory therapy, pharmacy, materials management, plant operations, environmental services, education and professional development, security, school of medicine, and numerous nursing and hospital senior leaders representing quality and safety, operations and finance. External partnerships included local and regional emergency medical services and transport and emergency management.

Similarities included the representation of team members for other unique patient care scenarios that VCUMC often encounters. A clear difference was that the MRICU was identified as the sole inpatient unit, regardless of age or patient condition that would provide ongoing care for these patients through their discharge, following their admission to the ED. This required significant and ongoing collaborations with patient care areas, such as the PICU, NICU and L & D, that had a very different patient population than what the MRICU team was used to caring for in their daily practice. In addition, identifying training strategies, to include seeking volunteers, formalizing the PPE processes and setting up training sessions required facilitation from nursing, physicians, epidemiology and emergency management departments.

The easiest part of our initial preparations was how ready our Epidemiology and Emergency Management departments were to support the ongoing learning needs of the team members. They were engaged and committed to ensuring safety remained our TOP priority! The part that created a great deal of discussion was staffing, specifically identifying additional full-time equivalents (FTEs) needs, both in the RN and Unlicensed Assistive Personnel (UAP) job categories. This immediately led to staffing coverage ("backfill") needs for the MRICU, PICU, NICU and L & D to support training and also in the case of receiving a suspected Ebola patient.

Walk us through your experience (and your team's) when your facility received their first possible Ebola patient. What support did the patient need and how did that affect your staffing?

R: Our first patient arrived in September2014. The patient presented to the Emergency Department (ED) with symptoms consistent with the initial stages of EVD and had recent travel to an area where the disease was present. The team immediately placed the patient in the designated area in the ED and initiated the Special Pathogens plan. The patient would be transferred to a designated MICU bed when available. In order to accept the patient in the MICU, patients in that area of the unit would need to be relocated to other available adult ICU beds.

Fortunately the patient remained hemodynamically stable throughout her hospitalization. Her care needs could be compared to a patient with flu-like illness. On day two her fever resolved and eventually she was ruled out for EVD. We were able to cover this patient with one nurse (single assignment) and a back-up team member (nurse or UAP) during her hospitalization. Because of the stability of this patient, the bedside nurse was able to leave the room for extended periods of time thus avoiding the exhaustion associated with prolonged time in PPE and the need for another team member to be present for relief.

The impact on staffing in this situation was minimal. For the most part we did not need a dedicated three-person team (nurse/nurse/safety officer) for this patient's care. In the event of a positive patient, the needs are extremely high. Conservative estimates for nursing care delivery are 8.4 full-time equivalents (FTE) per patient. In addition a safety officer/coach is also needed (another 4.2 FTEs) to maintain site safety, coach PPE donning and doffing, and provide administrative support to the care delivery team. This does not include the numerous FTEs required for support from other disciplines and services.

A: VCUMC's first suspected Ebola patient arrived in October 2014 during the night shift. This patient arrived to our ED and was immediately secured in an area pre-designated to care for these patients. Communications within the VCU Health System were immediate and swift and included numerous key departments/personnel who played a significant role in preparing for the patient's arrival in the MRICU. In preparing for this patient's arrival in the MRICU, a number of patients had to be laterally transferred to another ICU or relocated to another room in the MRICU. To provide safe care for this patient, the MRICU planned to close the room adjacent to the patient's room, which would be used for PPE procedures and storage of supplies. In addition, additional patient rooms would be closed, and the section of the unit where the patient would

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be located would be secured to ensure the patient's privacy was maintained.

Preliminary discussions prior to October 2014 regarding staffing included two RNs being available to care for this patient. Recognizing these RNs would come from the MRICU staffing pool, additional FTEs were added to our budget to support this need. We had presumed that due to the complex care these patients would require, RNs, in collaborations with our physician colleagues, would support the direct care needs of these patients. In October 2014, two RNs were assigned to care of this patient. In addition, our Epidemiology, infectious disease and emergency management departments supported our patient's plan of care. Numerous nursing, hospital and support service leaders supported the ongoing needs of the patient, unit and organization, including mass mail communications to the organization.

Lessons learned included to the need to have 12.6 RN FTEs to care for one patient and 21 RN FTEs to care for two patients. In addition, we recognized the pivotal role of the UAP in the care of these patients, hence, we suggested one UAP be available 24/7.

What were the most significant findings after your team's first encounter with this type of patient in 2014?

R: For the caregivers at UVA, the most significant finding was the exhaustive nature of wearing PPE for prolonged periods of time. This led us to change our way of thinking related to how we would deliver care. In a situation that required an increased level of care (days 4-10) for a positive patient, we would likely need even more caregivers. Limiting time of care delivery in PPE to two hours requires more donning and doffing. The second caregiver needs to be ready to enter the room when the first caregiver is scheduled to leave the room. Considering that it requires approximately 20 minutes to don the PPE and another 20 minutes to remove the PPE, you quickly realize that there is not much time out of PPE in that 2+ hour period of time.

A: Two very important lessons were learned at VCUMC from our October 2014 activation. First, the presence and participation of our epidemiology and emergency management colleagues were paramount in supporting the psychological and emotional needs of our staff. They, along with our infectious disease colleagues, were present around the clock for the first 48-hours and spoke with staff on the unit to clarify and de-mystify inaccuracies about Ebola and the disease process.

Second, we immediately recognized that our patient's level of care was that of a general patient, not requiring the ICU care delivery throughout their stay. However, we recognized that a patient with more complex needs would require additional RN staff to safely provide for their care. Hence, we readjusted our RN FTE requirements from two RNs to three RNs, in addition to an UAP, that would be needed to care for one patient. If we had two potential Ebola patients, we projected that we would need five RNs and one UAP to support these patients' needs.

What needs did your staff have that you did not expect, and how did this affect your staffing?

R: We have been able to anticipate 98% of team member needs from the beginning due to the fact that the front-line caregivers have been involved from the start. One thing we did overlook with the first encounter was the fact that our team should not leave the area to get food or drinks in other areas of the medical center. With our second encounter we had prepared food and beverages delivered to the unit for the team. During these encounters, we also convert one of the vacant patient rooms in the same area into a rest-and-relaxation area for the team. They are able to sit and eat as well as unwind and rest, but they are still readily available if needed.

A: Our staff had been present during discussions and training, proactively participating and making recommendations regarding procedures and processes. We anticipated that during and following activation, the staff would require ongoing support, so we engaged our Employee Assistant Program and chaplain colleagues to provide debrief sessions with all staff, including staff who were not directly involved in the patient's care, but were located on the unit during this activation (e.g., environmental services, pharmacy, food and nutrition services).

One of the biggest challenges we faced following our October 2014 activation was determining how to support the ongoing training needs we were faced with. However, VCUMC recognized this need and provided tremendous support for PPE training through our Education and Professional Development department, allocating resources to support these needs.

Did you make changes to procedures? If you did, what were they?

R: We have made several changes since our first encounter – too many to list here. Our plan is fluid and we continue to learn each time we do this. We also learn from our weekly exercises that involve our evolutions of training – Donning and doffing, labs and point-of-care testing, environmental services, and special populations.

A: The biggest change VCUMC made since our October 2014 activation was the redesign of an existing unit to become our Unique Pathogen Unit (UPU). This remodeled unit housed our February 2015 rule-out Ebola patient. The UPU can support the complex care needs of adults, children, neonates or laboring patients. In addition, the UPU has a dedicated lab that has the capacity to run a variety of tests, providing immediate results, as well as its own autoclave area that will support the waste management for the unit, as well as that from the ED for these patients. Recognizing that staff may not have the ability to leave the UPU, a break room with numerous amenities to support their health is available 24/7, including meals, snacks and beverages around the clock. Last, to support our daily practice of "Safety First", there are monitoring

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stations strategically located in the locker room, where staff first enter the UPU. We also created a hydration/shower area, where staff, after doffing their PPE, will be required to hydrate themselves and take a shower. These monitoring stations are equipped with devices to monitor vital signs as well as laptops used to keep accurate and timely records to support our staffs' wellness. We have also used various forums to support recruitment efforts and to demystify the UPU. Through these efforts, we have been able to increase the size of our staffing pool of volunteers!

Share your biggest takeaway from this experience – what do other nurses need to know about staffing for this type of experience/ patient?

R: The biggest takeaway is the amount of resources required – FTE, supplies, equipment. Most importantly for the caregiver is the training. It is more than just delivering the best care possible. It is taking care of the caregiver. Making sure they receive the necessary training and retraining. Making sure the team has what they need – from PPE to all of the necessary administrative support.

It takes a very large team to manage the special pathogen population. Training and support are the keys to success. We can care for this population safely. We just need to make sure all of the necessary pieces are in place.

A: It takes a village and there's no such thing as "over-communication"! We have many proud moments that have been experienced in this initiative, but none more proud than the efforts put forth by the numerous departments to ensure safety was always our top priority in caring for the unique needs of these patients. Further, communications during both activations with all key stakeholders was timely and open, where all felt safe to address plans and thoughts. These communications continue to occur twice a month to provide regular updates and identify priorities and gaps so that these are addressed in a timely fashion.

Do not underestimate the staffing requirements that are needed to care for unique pathogen patients with basic or minimal needs. The first 48-hours have been the most challenging time for staffing needs, especially for those areas supporting the reassignment of their staff to care for these patients. Identify on-call and backfill staffing structures that can support staffing needs. Finally, continue to keep staff engaged who are a part of the unique pathogen team. They are great advocates for the needs of their patients and fellow team members.

UVA's Special Pathogen Team at Work

VIRGINIA NURSES ASSOCIATION

The Virginia Nurses Career Center is a dedicated search and recruitment resource for nursing professionals and employers. We offer simple and easy-to-use tools to make searching for career opportunities and finding qualified professionals faster, more efficient and more successful than ever before.

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Find the most relevant nursing jobs from top employers

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2015 *Workplace Advocacy Guide* Now Available

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Old Dominion continued from page 1

"The perception of 'taking forever to complete the degree' can be a barrier to nursing students hoping to complete a bachelor's degree. This new collaborative program will help eliminate this barrier and help move forward the goals of the Virginia Action Coalition," said Karen Karlowicz, chair of Old Dominion University School of Nursing.

The second Academic Progression Pilot grant was awarded to James Madison University nursing program (JMU) in partnership with Southside Virginia Community College (SVCC) and Southern Virginia Regional Medical Center (SVRMC) for their NEARVa (Nurse Education Advancement for Rural Virginia) project.

The NEARVa program's goal is to make it easier for nursing students in southern Virginia to complete an RN to Bachelors of Science in Nursing (BSN) program at JMU. This grant funding will be used to improve access to baccalaureate nursing education for diverse nurses from educationally and/or economically disadvantaged in rural communities in southern Virginia. JMU will provide diverse students from SVCC and SVRMC with support and retention strategies, including detailed tracking of each student's progress and hands-on mentoring from a qualified life coach.

This funding will also aid in developing a new articulation agreement between JMU and SVCC, making the transition from the community college setting to the JMU BSN program easier for nursing students who wish to obtain a baccalaureate degree. NEARVa will also examine the barriers to nursing academic progression and work to develop enrichment and retention programs that will help keep nurses on the path to gaining higher levels of education.

"The social determinants of poverty, being educationally disadvantaged and lacking access to education opportunities negatively impact nursing students and residents of rural VA communities when compared to VA overall," said Nena Powell, program coordinator for NEARVa and JMU's RN to BSN program. "We want to improve access to nursing education by examining these barriers and using strategies to help nursing students overcome them. Ultimately, our goal is to improve the lives and health of residents of our area by helping to create more highly-educated registered nurses."

Medicare Payment "Fix" Includes Key Provisions for Nurses

APRNs Included in Incentive Program, Gain Ability to Order Medical Equipment

The American Nurses Association (ANA) applauds Senate passage of H.R. 2, the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act. This legislation protects seniors' and children's access to care and repeals the Medicare payment formula used to calculate Medicare payment rates to health care providers. H.R. 2, headed to President Obama for signature, includes provisions that enhance nurses' roles as providers and improve their ability to provide timely services to Medicare beneficiaries.

The legislation expands the range of health care providers permitted to document the face-to-face encounters with Medicare patients required to write prescriptions for durable medical equipment by including nurse practitioners and clinical nurse specialists. This change improves access to services and will allow Medicare patients to receive equipment, such as portable oxygen systems and hospital beds, sooner. Under previous law, nurse practitioners and clinical nurse specialists were required to certify that the order of durable medical equipment was based on a prior face-to-face visit with a Medicare patient as documented with a physician's co-signature.

The law also incorporates advanced practice registered nurses (APRNs), including nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists, in the new Merit-Based Incentive Payment System, which is based on quality, value and accountability standards. The incentive payment program replaces the Sustainable Growth Rate (SGR) payment formula, which was intended to control Medicare spending by tying physician payment changes to measures of overall economic growth.

"The provisions affecting nursing in this bill recognize that nurses provide high-quality, efficient and cost-effective services that are valued and needed by Medicare patients, many of whom rely on APRNs for their primary care needs," said ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN. "Nurses are more than ready to meet the quality and accountability standards for reimbursement and will continue to improve the health care experience for some of the nation's most vulnerable citizens."

ANA is also pleased that the legislation:

- Extends federal funding of CHIP, which covers more than eight million children and pregnant women in families that earn income above Medicaid eligibility levels, for two years.
- Provides $287.4 million to the National Health Service Corps Fund and Teaching Health Centers, for two years.
- Includes $7.2 billion in additional funding for federally funded Community Health Centers.
- Extends funding for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs through September 30, 2017. The MIECHV program provides funding support for evidence-based home visiting programs like Nurse-Family Partnership.