A new year! Synonymously, a new chapter, a new page, a new leaf... may be heard! No matter what 2017 is called, January is the “resolutions” month. Often the focus is on eating better, losing weight, and exercising more. Sound familiar? Then comes February, when all too often those resolutions are declared failed or not realistic. Numerous reasons come to mind that excuse these failures, usually accompanied by the thought that “later” might be a better time to reconsider these resolutions.

By the time this TON issue is received, you may have already completed the above process. So my challenge to you is to relook at the whole idea of resolutions right now, and create a 2017 Plan of Action (POA). This POA should have at least two prongs, although three are better in terms of balance and stability. Back in January, we all received ANA’s Grand Challenge. Nurses improving their health will greatly impact the health of the nation. ANA defines a healthy nurse as someone who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. Nurses should be viewed as role models of health for their patients, colleagues, families, and communities. Essentially, nurses need to practice what they teach!!! So in keeping with 2017 being the Year of the Healthy Nurse, let’s put those resolutions into a new perspective. Goals of looking like Barbie or running a marathon are probably not very realistic. But... we all can work on improving in at least one area as none of us are perfect... yet!

This means changing something we currently do or practice to something essentially healthier. Pick a change process and start developing your POA. Under a general or overarching goal, identify realistic small steps or mini-goals. Weave in some positive resources or actions that will decrease or eliminate barriers to change, like acquiring a partner or making a written commitment with a date and signature. Set a start date. Identify realistic outcomes so you’ll know when to move forward with new or higher goals. Build in actions for when you may slip up or fall off the POA. Think of this POA as your personal care plan for a healthier you!

Consider a second prong that focuses on legislation. The Governmental Affairs Committee (GAC) follows bills that are of interest to nursing, whether that be opening the Nurse Practice Act or impacts on core health services. Consider joining the GAC and becoming more active. At the very least, respond by contacting legislators when alerts are emailed out. Get to know those who are continuing and those who are newly elected. Offer your assistance with health-related bills. Share your experiences! Essentially, educate your legislators.

This next session will again challenge lawmakers in terms of budget, core needs, and new issues. Nurses need to step up and share information, personal and professional experiences, and solutions! This past session, lawmakers passed the interstate nursing compact. Next year we hope to work on full practice authority, which every nurse needs to support.

A third prong might focus on your community. Are you involved in schools through your children or grandchildren? Serve on a city committee? Volunteer at a free clinic or local shelter? If not, then consider an initial volunteer activity.

For the Year of the Healthy Nurse, ANA develops supportive web pages that provide resources, gather data, & generally serve to connect all the involved entities and their competitions. More resources are provided each month through a specific topic focus. January is Worksite Wellness, and February is Cardiovascular Health.

One of the resources available right now is the ANA Health Risk Appraisal. It can be accessed via the ANA web site and is free for use by any nurse. It will provide a great baseline of personal information to start the Grand Challenge. Do share the word about this free appraisal.

In our January board meeting, members of the board announced their 2107 goals. Several board members will be contributing to a Healthy Nurse Healthy Nation article series in upcoming issues of the Oklahoma Nurse. So, join in accepting the Grand Challenge, initiate your POA, become healthier, and share your successes this year. This is OUR Year!
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Contact information available at www.oklahomanurses.org

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**2017 Membership Dues Update**

To help ONA stay current with inflation, the ONA House of Delegates approved a dues escalator in 2004 that is tied to the Consumer Price Index-Urban (CPI-U) with a cap of no more than 2 percent per year. The increase is implemented every three years. The last dues increase was in 2014 and the next dues increase will go into effect in January 2017. This increase of $4 per year, or $0.34 a month, is to your ONA Membership only. You will notice the rate increase on your annual renewal date.

**Effective 1/1/17 ONA/ANA Dues will be as follows:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Full</th>
<th>Reduced/New Grad</th>
<th>Special</th>
<th>ONA/State Only Members</th>
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<tr>
<td></td>
<td>$284.50/$24.21</td>
<td>$142.25/$12.35</td>
<td>$71.13/$6.43</td>
<td>$139.50/$12.13</td>
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If you have any questions on the above, please feel free to contact us at memberinfo@ona.org or 1-800-923-7709 or in the ONA office at ona.ed@oklahomanurses.org or 405-840-3476.

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**ONA MISSION STATEMENT**

The Mission of the Oklahoma Nurses Association is to empower nurses to improve health care in all specialties and practice settings by working as a community of professional nurses.
CEO REPORT
Let them hear your voice!

Jane Nelson, CAE – CEO

As I write this column, the Oklahoma Legislature is weeks away from beginning session. Legislation is being introduced and we are waiving through the 2200 bills that have been filed. Legislators need to hear from nurses on Legislation. Solutions to many of the issues facing Oklahoma including the ever widening budget shortfall will have an impact on nurses, nursing and health care in our state. In addition, there are several pieces of legislation impacting the practice of nursing that have been introduced such as HB 1013 providing Full Practice Authority for ARPNs. In addition, we need to be mindful of bills such as SB 747 that would prohibit certified nurse midwives from performing vaginal births after cesareans outside the hospital and SB 714 that states only a nurse may call themselves a midwife. And there are many more. Legislators need to hear from nurses on the importance of these issues to the practice of nursing.

As we often say “Let Your Voice Be Heard,” but what does that really mean? It means being aware of current legislation affecting the nursing profession. It means serving as Nurse of the Day and speaking to your legislators one on one about issues that are important to you and nurses throughout Oklahoma. It means participating in Nurses Day at the Capitol on February 28 (more information is available on the ONA website), and it means sending emails or making phone calls to your legislators.

Serving as Nurse of the Day is a great way to be involved. It ensures that we have a Nurse every day at the Capitol during session to discuss nursing’s perspective on issues. As Nurse of the Day your Senator and Representative introduce you on the floor, you are provided the privileges of the chamber and a resolution regarding your participation. It is a great way to talk to Legislators regarding issues that affect your practice, your license and your patients. To learn more go to the ONA website, oklahomanurses.org, click on events, and Nurse of the Day.

ONA will work to keep you updated on these issues with talking points and legislative alerts so that we can all speak with one voice on these very complicated issues. But we need you to lend raise up your voice!

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10th Annual Faith Community Nurses’ Association Conference
Collecting the Wisdom: Harnessing the Power of Faith Community Nursing will be the title of an early spring conference for nurses, health professionals, clergy and anyone interested in gaining skills in a caring ministry in their faith community. The 10th annual Faith Community Nurses Association 2017 Conference is scheduled for Friday, March 3, 2017 at Crossings Community Center, 10255 North Pennsylvania Ave, Oklahoma City OK. This conference will explore the progression of Faith Community Nursing, use the Book of Esther to examine the role of Faith Community Nursing, encourage Faith Community Nurses to discuss their own individual ministry activities, and examine a pastor’s perspective of implementation of health initiatives in a congregation. Nationaly known, Susan Dyess, is certified in Advanced Holistic Nursing and as a Nurse Executive. In her early career as a registered nurse, she worked in a critical care unit, on an oncology unit and as an adjunct faculty member. She currently works in her community as a member of the Strategic Nursing Advancement Committee and as a Board Member the Delray Medical Center. She is very involved in research and has many peer-reviewed publications and presentations.

This conference will provide the opportunity for participants to network, build relationships with nurses and health ministers interested in Faith Community Nursing. The purpose of the conference is to increase awareness of Faith Community Nursing in Oklahoma, provide tools to enhance ministry of caring in a congregation, and open doors to networking among clergy, nurses and community services.

Registration for the one-day conference prior to February 18 is $50 for FCNA OK members. Non-member fees are $90. Nursing students fees are $60 and clergy fees are $65. Between February 19 and 28, add $25. Registration March 1-3, add $45. Refunds after February 18. FCNA OK is approved as a provider of continuing nursing education by the Kansas State Board of Nursing provider number LT0298-0316, KAR 60-7-107 (b)(3)(C).

Refunds before 2/18 less $20 deposit. No refunds and 28, add $25. Registration March 1-3, add $45.

For registration and brochure, see the FCNA website, downloads page: www.fcnaok.org or contact website, downloads page: www.fcnaok.org or contact Brenda Rice at 405-642-1512, brenda@rice.net.

We welcome feedback and contributions for the column Let them hear your voice! Deadline is October 15. Contact Jane Nelson, CAE at 918-423-3947 or jnelson@onaok.org.
Humor: It’s in the Details

Diane Sears, RN, MS, ONC

I think my comedy came from observing little details in life. What is most important are the details, not the broad strokes but noticing what’s in between. One of my first jokes was the fact that when somebody tastes something disgusting, they always want you to taste it too, like, “This is disgusting, taste it!” And people do. (Ellen DeGeneres)

Strange new trend at the office. People putting names on food in the company fridge. “Today I had a tuna sandwich named Kevin.”

Sign: “Please do not touch my mug.” Taped to the mug is a picture with several hands touching it with the statement, “We can’t help it, it’s so beautiful.”

“This printer is here temporarily,” Response, “In the greater scheme of things, aren’t we all?”

An email went around the office about a lost pen. This appeared the next day.

“I have the pen. Place $50 in a plain white envelope & place into the Telecom mail slot or the pen gets it. Do not notify HR or Management or the pen gets it. The pen is very scared and wants to go home but I will have no problem running it out of ink & throwing it into the garbage if you do not follow my instructions exactly.”

Upon opening the refrigerator door, most of the items are taped with notes marked, “NOT DEBBIE’S.”

Housekeeping missed a dead cricket in the corner. A full blown memorial was created with the following signs. “Justice for Jiminy. Rest in peace, Mr. Cricket, You will be missed.”

Boss talking to HR Rep: “The one called Dilbert is showing signs of happiness at work. That means we can give him more work and he won’t quit, excellent. Is anyone else exhibiting signs of unauthorized happiness? No, everyone else is in the narrow band of misery you want them to be in. If they were any happier, it would mean you’re overpaying them. If they were any less happy they would take their own lives. If you don’t hear any laughing or screaming, it means you’re doing something right. What about moans? Moans are ideal. That’s the sweet spot.” (“Dilbert,” cartoon, Scott Adams, 01/01/17)

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Details of Life


“Yesterday I picked up a prescription at the drugstore. The pharmacist asked me if my birthday was still August 27. I told him I had no idea why it would’ve changed, unless he knew something I didn’t know, and if so, could he shave off 10 years? He was not amused.” (“Pickles,” cartoon, Kevin Fagan, 11/5/16)

“Sometimes being a grandparent...means grabbing Doritos out of the package...only to discover that someone...has sucked all the flavor off them and put them back.” (“Pickles,” cartoon, Kevin Fagan, 7/1/16)

“I’ve been having a lot of, um, gas lately, Doc. How bad is it? I walked into a pet store and a canary died.” (“Shoe,” cartoon, Brookins & MacNelly, 6/18/16)

“Inwir, my back hurts. Call my cellphone and let it ring. I put it in my back pocket and set it on vibrate.” (“Broom Hilda,” cartoon, Russell Myers, 7/4/16)

“Oh shoot! I really need to start proofreading what I write on Facebook. I was just wishing my sister a Happy Birthday, I thought I wrote “I hope you get spoiled today.” But instead I wrote, “I hope you get spoiled today.” (“Pickles,” cartoon, Kevin Fagan, 7/2/16)

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Unconscious Bias in Nursing

Tonie Metheny, MS, RN, CNE
Fran and Earl Ziegler College of Nursing
University of Oklahoma Health Sciences Center

My experience of being a Vietnamese-American woman from Oklahoma has provided personal experience with being on the receiving end of both overt and covert racism. It was only recently, while on a road trip with several friends, that the owner of a convenient store refused to allow me to use the restroom. Everyone else in the car was allowed to use it. Everyone else was Caucasian. Even well-intentioned people occasionally make comments that are coated in an unseen, unrealized bias. My experience with racial bias shaped my thinking with regards to nursing.

Like every nurse, I entered into the profession with the belief that all people, everywhere are equal and should be treated equally, especially in healthcare. There is no room for biased nursing care. I was firm in thinking that I would never be the deliverer of prejudiced care. My care would always be unbiased.

Recently, a class on the human experience of disability challenged this belief. Students were asked to address their unconscious bias by taking a quiz that identifies implicit associations – covertly held beliefs about a group of people. Upon taking the test myself, I learned that although I consciously believe that all people are equal, it took me longer to associate positive emotions with people who have a disability than it did for people who were not disabled. I, in fact, have unconscious bias.

This is a common experience among people (nurses included) who otherwise consider themselves to be altruistic. Despite a conscious belief that all genders, races, ages, and backgrounds should be treated equally in nursing care, at an unconscious level, bias persist to exist. These biases affect the care we administer in the subtlest ways that ultimately negatively impact patient outcomes.

It's difficult to think that something you aren't even aware of may be causing you to treat patients differently. How does unconscious bias influence patient outcomes? Imagine these scenarios:

A nurse on a labor and delivery unit is assigned to care for a 14-year-old girl who is non-English speaking. She is in active labor. Although the mother and baby are monitored adequately from the nurse's station, the nurse spends less time providing effective laboring strategies and coaching than she normally would.

An emergency room nurse is assessing a homeless patient who admits to a history of illicit drug use. The patient states that he is in pain and rates it 8/10. The nurse has another patient who is from an affluent background who is also in pain and rates it 8/10. The nurse administers more pain medication to the affluent patient than to the homeless patient.

A nurse in the operating room is preparing a patient who is morbidly obese for surgery. The nurse does not cleanse the patient's skin as thoroughly as he normally would and the skin prep is not congruent with unit protocol. The patient later acquires an incisional infection.

From these examples, it's clear that the care we give is informed by bias and does impact the health of the patient on the receiving end of that bias. Less obvious, but still equally pervasive are biases towards education, insurance coverage, health literacy, medical history, sexual orientation, and disability. It may be difficult to accept the evidence of unconscious bias, as well as the ramifications, but it is a necessary step in administering more equitable care.

There is a solution. The Joint Commission has outlined strategies for nipping unconscious bias (2016). The first step is recognition of your personal bias by taking the Implicit Association Test at implicit.harvard.edu. Next, reflect on the findings of the test and develop an awareness on how it could impact the care you give to patients. Ask for training and opportunities to discuss feedback with other healthcare providers on your unit. Finally, whenever possible, use care algorithms or plans of care to ensure equitable care is provided. Standardizing health care across populations is one way that bias can easily be eliminated.

References
Join us for Nurses Day at the Capitol of February 28th! Registration is open: www.OklahomaNurses.org

ONA encourages all Nurses and Nursing Students to get involved in the legislative process by attending Nurses Day at the Capitol. The day begins with an informational session held at the National Cowboy and Western Heritage Museum in Okla. City, followed by an opportunity to go to the Capitol and talk with legislators.

The Importance of Nurse of the Day

Oklahoma Nurses Association’s Nurse of the Day (NOD) program serves as an effective advocacy tool for nurses across the state to talk one on one with Legislators. The NOD has the opportunity to visit with legislators, attend various committee meetings and assist in the First Aid station at the Capitol. The program allows nurses to voice their thoughts and opinions on current legislation that affects nurses and healthcare.

Many professional associations are trying to get legislators to take notice of their views. It is imperative that we have nurses to serve as NOD. The NOD is introduced on the chamber floor at the beginning of the session and presented with a personalized certificate of appreciation. During the legislative session, access to the chamber floor is reserved to a few privileged people, which includes the NOD. This honor allows the NOD beneficial one on one time with the legislators to discuss their views on current bills.

Please consider serving as NOD sometime from February to May. In addition to signing up to be a Nurse of the Day, you can also choose to serve in honor of Rebecca Anderson on April 19th or Florence Nightingale on May 11th. Nurses are the largest group of health care providers in the state! There are many issues that come before the Legislature that may affect the delivery of care, the nursing profession and nurses in general during the next session. It is imperative that Nurses are there to weigh in on these issues. The Oklahoma Nurses Association’s Nurse of the Day has proven through the years that it provides visibility and an opportunity for nurses’ voices to be heard throughout the Capitol. Sign-up on the ONA website www.oklahomanurses.org or call 405.840.3476.

What Nurses are Saying About Serving as Nurse of the Day...

“Valuable time spent advocating for the care of my patients. Well worth the time and effort.”

“I felt as though my representative and senator listened to me and my concerns. I felt welcome, I felt heard, and I felt as though I made a contribution on behalf of my profession. I felt proud to be a nurse from this fine state.”

“Great opportunity to make a difference to your community, let your voice be heard and to see how the Oklahoma legislature operates.”

“I felt appreciated and proud to represent the nurses of Oklahoma.”

“Just show up! A majority of what we do as nurses requires being present in the lives of those we care for be they family or patients. The opportunity to be The Nurse of the Day at the state capital is powerful. By not filling every day on the legislative calendar with a Registered Nurse we are doing the profession a disservice. Come join the Oklahoma Nurses Association and “just show up” as Nurse of the Day.”

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Happy National Nurses Week
May 6-12, 2017
A Case for the Nursing Informatics Executive

Rachel Webb, BSN, RN-BC
Paula Maisano, PhD, RN, CNE

Nurses are overwhelmingly the largest group of healthcare workers to use and input information into the electronic health record (Harrington, 2012). Additionally, data gathered by nurses effects nursing practice, clinical outcomes, and evidence based practice (American Organization of Nurse Executives [AONE], 2012). Due to the large volume of data analytics and the complexities of health information science, Nursing Informatics (NI) has matured and developed resulting in the need for a new nurse leader role: Nursing Informatics Executive (AONE, 2012). The Nursing Informatics Executive (NIE) role should be defined, understood within the matrix of the executive co-workers, benefits of the role described, educational requirements explained, and barriers acknowledged.

Nursing Informatics (NI), defined as the blending of computer science, information science, and nursing science, has been a recognized specialty by the American Nurses Association since 1992 (American Nurses Association [ANA], 2008). NI “professionals are key liaisons to successful interactions between practice, technology, and patients” (AONE, 2012, para. 2). In 2012, the American Organization for Nurse Executives (AONE) determined the unique need for NIE’s to lead as the health care environment is swiftly changing due to the NIE’s understanding of clinical decision support, designing of information systems, nursing clinical knowledge, reporting, communicating, and influencing organization change in a competitive market (AONE, 2012). The NIE is a strategic and operational leader for the organization (Swindle & Bradley, 2010).

Murphy (2011) believes the success of an NIE lies within the association with other significant executive stakeholders in the organization: Chief Nursing Officer (CNO), Chief Information Officer (CIO), and Chief Medical Informatics Officer (CMIO). Dotted lines or direct reporting to the CNO and CIO has shown to be an effective structure and leads to a strong acceptance and cultural infusion of health information technology (Murphy, 2011). Furthermore, a NIE “knows the link between technology and outcomes, and can ensure performance measures of both clinical and financial outcomes” (Murphy, 2011, p. 152). The NIE may be responsible for other disciplines besides nursing, but the role must be held by a registered nurse (Swindle & Bradley, 2010).

Benefits of an NIE have been seen since the 1800’s with Florence Nightingale who is considered the antecedent of the contemporary NIE (Manos, 2012). Other benefits include patient and co-worker advocacy, providing a transformative patient experience by leveraging technology, streamlining of patient data, maximizing productivity by establishing documentation standards, and restructuring so that all systems are efficient and operative for optimal patient care (Lucius, 2012).

The predominance of informatics in nursing has grown exponentially necessitating the particular need for the NIE role. Moreover, NIEs are needed as a specific leader to provide “the vision, influencing health IT decisions, and providing leadership to successfully meet the challenges of a continually evolving technologic environment” (Kannry et al., 2016). NIEs are responsible for the adoption and expansion of the electronic health record (EHR), operational informatics challenges, organizational optimization of the EHR, an expert in clinical documentation, Meaningful Use authority, champion of evidence-based practice assimilation into the EHR, sets
The Oklahoma Nurse  
March, April, May 2017

2017: YEAR OF THE HEALTHY NURSE

Balance your life for a healthier you.

In recognition of the impact that increased nurse health, safety, and wellness has on patient outcomes, quality of care, and overall nurse satisfaction and quality of life, American Nurses Association (ANA) has designated 2017 as the “Year of the Healthy Nurse” with the tagline of “Balance your life for a healthier you.” Each month will highlight various health, safety, and wellness topics important not only to nurses, but to their co-workers, families, patients, and the communities in which they live, work, and play. Nurses struggle with multiple health, safety, and wellness challenges. ANA’s 2016 Health Risk Appraisal shows alarming trends for registered nurses (RNs) and nursing students:

- An average BMI of 27.6 (overweight)
- 12% have nodded off while driving in the past month
- Only 16% eat the recommended daily amount of fruits and vegetables
- Less than half perform the recommended quantity and time of muscle-strengthening exercises (ICG & ANA, 2016)

RNs continue to rate workplace stress as a hazardous occupational risk well above the national average (ICG & ANA, 2016). Yet nurses’ very calling, professionalism, and strong sense of ethics demand that they become better role models, advocates, and educators.

2017 brings a focus on the Year of the Healthy Nurse, and will include the launch of the Healthy Nurse, Healthy Nation™ Grand Challenge (HNHN GC) and the continuation of #FitNurseFriday. ANA’s HNHN GC is a sweeping social movement to increase the health of the United States’ 3.6 million RNs, thereby impacting and improving the health of the nation. HNHN GC focuses on five fundamental indicators of wellness: rest, nutrition, activity, quality of life, and safety. These five wellness indicators are incorporated into ANA’s Year of the Healthy Nurse topics to ensure RNs receive cohesive messaging and assistance on their journey toward their best health ever!

Visit www.nursingworld.org/2017-Year-of-Healthy-Nurse today for more information!

Reference:

Jennifer Booms, BSN, RN  
ONA Director of Emerging Nurses  
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Jennifer Booms, BSN, RN  
ONA Director of Emerging Nurses  
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New Emerging Nurse Director

ONA is excited to announce the new Emerging Nurse Director, Jennifer Booms. Jennifer was raised by her parents along with four siblings in Mustang, Oklahoma where she graduated valedictorian from Mustang High School. Throughout high school, Jennifer ran cross-country and was actively involved in competitive dance. In her leisure time Jennifer enjoys camping, riding ATV’s, exploring different teas, spending time with her husband, family, and friends, and cuddling with her dog and cat. Jennifer earned her Bachelor of Science in Nursing from the University of Central Oklahoma in May, 2015. During college she was a member of both the Alpha Lambda Delta Honor Society and Student Nurses Association. Jennifer began her nursing career at Mercy Hospital, where she currently works on the Intensive Care Step Down Unit. As a registered nurse, she finds great fulfillment caring for critically ill patients and enjoys precepting newly licensed nurses and assisting them with a smooth transition into the nursing field. Jennifer Booms was recently appointed as the Director of Emerging Nurses for the Oklahoma Nurses Association. She is very excited to assist in creating a supportive and nurturing environment for newly licensed ONA members. If you are interested in participating in Emerging Nurse activities this year, please contact Candice Black, ona@oklahomanurses.org.

Jennifer Booms, BSN, RN  
ONA Director of Emerging Nurses  
Jennifer.Boom@mercy.net

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<td>December</td>
<td>Healthy Eating/Healthy Holidays</td>
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ANA President Responds to Department of Veterans Affairs Final Rule on APRNs

SILVER SPRING, MD – The Department of Veterans Affairs (VA) released a final rule granting full practice authority to three of the four established Advanced Practice Registered Nurses (APRNs) roles when they are acting within the scope of their VA employment. Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) and Certified Nurse-Midwives (CNMs) will now have full practice authority within the VA Health System as a mechanism for extending veterans access to a full range of qualified health professionals. ANA is disappointed that the VA failed to extend full practice authority to Certified Registered Nurse Anesthetists (CRNAs).

The following statement is attributable to American Nurses Association (ANA) President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, in response to the final rule:

“The American Nurses Association is pleased with the VA’s final rule allowing APRNs to practice to the full extent of their education and training. This rule puts veterans’ health first, and will help improve access to the timely, effective and efficient care they have earned. However, ANA is concerned with the final rule’s exclusion of CRNAs, which is solely based on the VA’s belief that there is no evidence of a shortage of anesthesiologists impacting access to care. We join with our colleagues in continuing to advocate for CRNAs to have full practice authority within the VA health care system.

“The 6,000 APRNs serving in the VA health care system are dedicated to delivering the best possible care to our heroes and their families. Today’s rule is the right policy at the right time, and we applaud the VA for taking this vital step in ensuring access to care and keeping America’s veterans healthy.”

APRNs are nurses who have met advanced educational and clinical practice requirements, and whose services range from primary and preventive care to mental health, birthing and anesthesia.

The proposed rule generated an unprecedented number of comments from veterans, health care providers and the general public. The final rule amends the VA’s medical regulations to permit full practice authority (FPA) for three of the four APRN roles when they are acting within the scope of their VA employment and authorizes the use of APRNs to provide primary health care and other related health care services to the full extent of their education, training, and certification, without the clinical supervision or mandatory collaboration of physicians.
Mindfulness-Based Childbirth Parenting (MBCP) Program: Impact on anxiety and stress during labor

Mary Phillips, BNS, RN; Kelsey Brittingham, BSN, RN; Tera Oss, BSN, RN; Hunter Eaton, BSN, RN; and Amy Frana, BSN, RN. (OUHSC College of Nursing)

Faculty consultant and mentor: Dr. Paula Maisano, PhD, RN, CNE

Anxiety and stress are notably prevalent among the pregnant population and may negatively impact maternal and neonatal health. Despite this high prevalence rate, current childbirth education does not address mental health improvements, and there are few non-pharmacologic treatments available for women to manage symptoms of anxiety and stress during pregnancy and labor in the hospital.

Anxiety influences the laboring process in various ways including: stimulation of the sympathetic nervous system, which causes vasoconstriction to occur resulting in a reduction of blood flow to the placenta, inefficient breathing due to anxiety, which can hinder cervical dilation due to muscle tension, and tightening of the pelvic floor, which can result in a longer labor duration increasing risk of complication for mother and baby (Reck et al., 2013). In addition, the literature demonstrated correlations between an increased need for obstetric interventions, poor psychological health, increased risk of preterm delivery and lower birth weight, low Apgar scores, complications intra and postpartum, and infant socioemotional, behavioral and neurocognitive developmental issues.

Throughout the United States, the childbirth process has become heavily influenced by medical and pharmaceutical interventions failing to provide women with natural alternatives for managing anxiety during labor. Traditionally, the most common non-pharmacological methods available for pregnant women are relaxation during childbirth education classes and techniques focusing specifically on breathing, relaxation and distraction. These techniques have been used for many years but have fallen short in providing a significant level of relief of anxiety symptoms during labor. An accumulation of evidence has been identified supporting the effectiveness of a novel mindfulness-based education program taught during childbirth classes as an alternative to the traditional childbirth education.

Kabat-Zinn (1994) defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, non-judgmentally” (as cited in Duncan & Bardacke, 2010). The Mindfulness-Based Childbirth Parenting (MBCP) program was developed by Nancy Bardacke, RN, CNM, MA in 1998 as a formal adaptation of the Mindfulness-Based Stress Reduction program. MBCP education has been found to decrease perceived maternal stress and anxiety, as well as, improve psychological functioning (Byrne, Hauck, Fisher, Bayes, & Schutze, 2013). Specifically, the MBCP program offered during prenatal classes was shown to be an effective method for decreasing anxiety and stress, and improving psychological well-being during pregnancy, childbirth, and the transition to parenthood (Duncan & Bardacke, 2010). As mindfulness assists in reducing the length of labor and unintended complications, there is potential to see a decrease in rates of births with complications. Consequently, as shown in Table 1.1, by decreasing the number of births with complications, mindfulness would likely reduce length of hospital stay and cost for the hospital organizations.

While current traditional childbirth education does include relaxation techniques, pain management, and the basics of labor, postpartum care, breastfeeding, and other aspects of physical health, it does not specifically address mental health of mother and baby. As shown in Table 1.2, the MBCP program delves deep into practicing the mindset of focusing on the present, rather than stressing about what could possibly go wrong in the future. In other words, the goal is to reduce the perception of pregnancy, childbirth, and parenthood stressors as scary or painful, and allow couples to create their own childbirth experience. Families who completed the program experienced positive stress reduction in other aspects of their lives as well.

Mindfulness education provides women with a natural technique to use during labor to reduce anxiety symptoms and has been shown to reduce rates of complications during labor, improve overall well-being of mom and baby, as well as decrease the duration of labor. Integrating mindfulness in childbirth education programs would be an easy to teach, low cost alternative therapy to utilize during labor. The recommendation for change involves the addition of the MBCP program into the current childbirth education curriculum throughout hospitals in the USA, as an option for pregnant mothers to pursue.

Table 1.1

<table>
<thead>
<tr>
<th>Pregnancy and childbirth stays with and without complicating conditions</th>
<th>With complications</th>
<th>Without complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean length of stay (days)</td>
<td>2.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Mean hospital costs</td>
<td>$3,900</td>
<td>$2,600</td>
</tr>
<tr>
<td>Aggregate costs</td>
<td>$15.5 billion</td>
<td>$0.6 billion</td>
</tr>
</tbody>
</table>

Table 1.2

| Traditional Childbirth Education vs. Mindfulness Based Childbirth Parenting Program |
|---|---|
| **Average Length** | Traditional | MBCP |
| | 12 week program | 9-week course, 3 hours per week |
| | | 6 weeks of home practice |
| | | Silent, daylong (7hr) retreat |
| | | Reunion class after women have given birth |
| **Interventions** | Relaxation techniques | Loaningkindness practice |
| | Labor rehearsal | Mindful pain practices |
| | Postpartum care | Mindful partner communication |
| | Breastfeeding | Lovingkindness practice |
| | | Thread of mindfulling |

References


ONA and ANA’s strategic goals have always included advocacy for a health care system where RNs and APRNs can practice to the full extent of their knowledge and professional scope of practice.

**Therefore**, it is the position of the Oklahoma Nurses Association that it supports full practice authority for Advance Practice Registered Nurses in Oklahoma.

ONA and its members will advocate state legislation to provide full practice authority for Advance Practice Registered Nurses in Oklahoma. In addition, ONA and its members will advocate state legislation to allow APRNs with prescriptive authority to write Schedule II – V drugs in accordance with their role’s scope of practice.

ONA also supports credentialing of Advance Practice Registered Nurses by insurance companies and facilities.

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Full Practice Authority for Advance Practice Registered Nurses (APRN) - HB 1013

- House Bill 1013, by Rep. Josh Cockroft would grant nurse practitioners and other advanced practice registered nurses full authority to provide primary care services.
- Currently, supervision is only on prescriptive authority for APRNs. In Oklahoma 54% of APRNs report paying their supervising physician for this service. Fees range from a monthly fee to percentage of gross payments received.
- Physicians are limited to supervision of two APRNs by the Board of Medical Licensure and Supervision/Osteopathic Licensure Board. APRNs must find a physician that is in a similar field and for some specialty areas such as Psych/Mental Health that is difficult since Oklahoma is on the HRSA Shortage list for Psychiatry.
- Changes in supervising physicians are related to moves, retirement, deployment etc. These changes cause disruption in providing care to Oklahomans.
- The bill would do away with a formulary committee that currently recommends prescription authority rules to the Board of Nursing. That committee currently includes M.D.s and D.O.s. The new language would give that rulemaking authority directly to the Board of Nursing.
- By allowing NPs and APRNs to practice at the full scope of their capabilities, Oklahoma would have an opportunity to:
  - Increase access to affordable health care, particularly in rural areas;
  - Address a shortage of primary care providers;
  - Offer consumers shorter drives and shorter wait times;
  - Improve public health;
  - Offer consumers the freedom to make the health choices that are right for them and their families.
- Passage of the bill would also spur economic development in rural parts of the state. Businesses are unlikely to relocate to areas without an adequate health care infrastructure. Plus, each new clinic that opens creates new jobs.
- Oklahoma is one of only 12 states that require a physician to supervise APRNs in some way. Twenty-one states and the District of Columbia offer APRNs full practice authority. Seventeen states have laws that fall between restricted practice and full practice authority for APRNs.
Barriers do exist in the formation of an NIE. There may be financial limitations, a coworker may have this role in an informal capacity, senior leadership may not understand the need for this role, the limited size of an organization, and the requirements have not been well-defined (Hodges & Wierz, 2012). However, as the role is further utilized and understood, the barriers may be fewer in the future.

In conclusion, nursing informatics has evolved over the past twenty-five years as a crucial member of the healthcare team (Remus & Kennedy, 2012). The evolution of the NIE is bringing a “broad perspective on health care delivery” (Harrington, 2012, p. 17). An NIE can complement an organization’s leadership by uniquely translating information science, technology science, and nursing science to a healthcare system. The NIE will help lead the charge in an ever changing healthcare environment by embracing and applying data for better patient outcomes and enhancing the future of nursing practice.

References

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• Recovery Room (Job ID # 2180, 3947, 5619)
• ICU (Job ID # 293, 2956)
• OB/Labor & Delivery (Job ID # 42, 1790, 5697, 6069, 6073, 6075, 6095, 6348)
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