The Nursing Voice

The Official Publication of the Illinois Nurses Foundation
Quarterly publication direct mailed to approximately 185,000 RNs in Illinois.

VOLUME 7 | NUMBER 1 | JUNE 2019

Student Nurse Political Action Day 2019

The 21st Annual Student Nurse Political Action Day was held on April 2, 2019, in Springfield, Illinois. Over 1000 nursing students from 37 different colleges of nursing attended this year's event. (see list below). The event is again supported by a generous gift donated in 2013 by the former Chicago Nurses Association. A big thank you to our other sponsor this year goes out to Grand Canyon University. For the 3rd year in a row, Mennonite College of Nursing at Illinois State University was honored for having the largest group of students attend. This annual event continues to excite and inspire students and has become a tradition for several colleges across the state of Illinois.

This year ANA-Illinois launched the I AM ANA-ILLINOIS campaign to encourage member interaction through sharing their stories and experiences. The campaign was incorporated into a photo contest that took place throughout the day. Students entered by submitting snap shots of their experience at Student Nurse Political Action Day with the hashtag #IAMANA-ILLINOIS via ANA-Illinois social media accounts. Each photo was counted as an entry for a drawing to win $100. Thank you to the many students and faculty that participated and congratulations to the contest winner, Shannon Fore from Kishwaukee College. The event also held its annual poster contest with this year's theme being "Caring for your community – the Role of the Public Health Nurse." Congratulations to the 1st place winners Alana Austin, Nicole Wulfe, Emily Shearer – Sauk Valley Community College.

Students spent time visiting with exhibitors throughout the morning and learned about legislative processes leading up to the march to the capital. The most influential part of SNPAD was the opportunity for the students to learn about multiple bills that are before the House of Representatives and the Senate that affect nurses, nursing students, and their patients. Speakers included Dan Fraczkowski MSN, RN, ANA-Illinois President, Vanessa Soto, SNAI Legislation Director, Jordan Powell – Illinois Primary Health Care Association, Sara Howe – Illinois Association for Behavioral Health, Josh Evans – Illinois Association of Rehabilitation Facilities and Sue Clark, ANA-Illinois Lobbyist. Six students (Allie Simkin – Graham Hospital School of Nursing, Abby Mustread – ISU Mennonite College of Nursing, Nicole Greewe – Loyola University, Kayla Green – Millikin University, Vanessa Tamayo – North Park University, Kristen Mueller – Student Nurses Association of Illinois President) led a march to the Illinois State Capitol building where many had appointments with their local legislators to discuss the bills of importance. Spectators watched as student nurses flooded the streets of Springfield letting the city know that political activism is important to the nursing profession.

Thank you to the attendees that made this an overwhelming success and helped to bring awareness to nurses and nursing students of the importance of political activism for nursing.

List of Colleges participating in SNPAD 2019

- Aurora University
- Blessing-Rieman College of Nursing & Health Science
- Carl Sandberg College
- Chamberlain University
- Chicago State University
- DePaul University
- Dominican University
- Governors State University
- Graham Hospital School of Nursing
- Illinois Eastern Community Colleges-Frontier Community College, Lincoln Trail College, Olney Central College, & Wabash Valley College
- Illinois Wesleyan University
- Indiana Wesleyan University
- Mennonite College of Nursing, Illinois State University
- Kishwaukee College
- Lewis University
- Lewis & Clark Community College
- Loyola University Chicago
- MacMurray College
- Millikin University
- Northern Illinois University
- North Park University Chicago
- Oakton Community College
- Olivet Nazarene University
- Purdue University
- Rasmussen College School of Nursing

SNPAD 2019 continued on page 4

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Lobby Day 2019

On Wednesday, April 3, over 100 nurses from across Illinois assembled in Springfield. Registered nurses and Advanced Practice Registered Nurses gathered to hear updates about the current bills that are in the House of Representatives and the Senate. ANA-Illinois and ISAPN recognize that truly impactful advocacy requires building a relationship, establishing trust, sharing manageable content, and having multiple contacts, perseverance, and follow-up to get results. We hope that hosting an annual Lobby day leads to an understanding that nurses need to get involved in policies that directly impact their careers and their ability to provide care for their patients. We believe the energy and resources expended on this event is just a start of a continuum of activism and we are committed to spending time helping nurses learn and practice advocacy skills and give them opportunities to grow as advocates. We know it is vital that we have nurses represented in the discussions and decision about the issues that matter most to us.

The nurses then visited the Illinois State Capitol to meet with their legislators to discuss the bills, create awareness, and become a resource on nursing issues. This is always a great event that showcases the work happening throughout the state as nursing organizations strived to improve access and quality of healthcare for the citizens of Illinois.

If you would like more information on any of the bills listed and their status, please visit the Illinois Nurses' Grassroots Coalition website. The most updated information can be found there. We are hopeful in the success of all of our major bills running this year and will continue to provide updates through our Legislative Reports given by Sue Clark and Debbie Broadfield.

The Nursing Voice

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- Subject to editing by the INF Executive Director & Editorial Committee
- Electronic submissions ONLY as an attachment (word document preferred)
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- Subject Line: *Nursing Voice* Submission: Name of the article
- Must include the name of the author and a title.
- INF reserves the right to pull or edit any article / news submission for space and availability and/or deadlines
- If requested, notification will be given to authors once the final draft of the *Nursing Voice* has been submitted.
- INF does not accept monetary payment for articles.

Article submissions, deadline information and all other inquiries regarding the *Nursing Voice* please email: kristy@sysconsultingsolutions.com

Article Submission Dates (submissions by end of the business day)
January 15th, April 15th, July 15th, October 15th

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MESSAGE FROM THE INF PRESIDENT

By Cheryl Anema Ph.D., RN – INF President

Cheryl Anema PhD, RN

As I sat down to write my Presidents Corner, I looked out the window to see squirrels running, birds flying, and the tiny buds of new life on the trees. Yes, Spring is here. For me, Spring brings a reflection on my life and those things close to my heart. Of course, the IL Nurses Foundation (INF) is near the top of the list.

The INF has come a long way since its initial induction. We have grown to a name that nurses recognize around the state. We have established numerous scholarships across the state for nursing students at all levels of nursing education. The INF sponsors a couple of programs every year that are purposed to recognize and honor nurses. The 40 Under 40 program brings in young nurse leaders from all areas of nursing — the same with our Honor a Nurse Recognition program. Our "regular" events have grown over the years to the point we have moved to larger venues. Our new Grant program is just taking off as nurses are applying for Research or Small project Grants through the INF.

Moreover, now, we are starting to see cars driving up and down the streets of the state displaying the "nursing" license plates which further supports the Foundation. Every time someone purchases and renews their vehicle license plate through the State of IL and chose the Nursing Specialty Plate, a portion of the plate fees are sent to the INF. Some of you may have signed up for the program and sent in your $20 a couple of years ago, but not everyone has taken the next step to go to the IL state website to place your order.

All of this is to say, we could not have grown and cannot continue to grow without the volunteers and donors supporting the Foundation. As we expand our programs, we look for more volunteers to help with the committees and events, as well as the Board of Directors. Everyone has different talents, talents that the Foundation would love to experience.

Have you ever thought about volunteering in a nursing organization but did not know how to get involved? Do you have an hour or two a month that you can dedicate to the advancement of nursing? The INF would love to talk to you about opportunities in the Foundation. We are not looking for full-time volunteers or only people that have a lot of time with nothing to do. Some of the volunteer opportunities may only require a remote meeting several times a year. Alternatively, maybe you love to plan parties and can help us with the Annual Fundraising Gala each December. We are looking for nurses from all geographic areas of the state, from diverse clinical or academic settings, and especially for those newer nurses looking to advance in nursing and develop their leadership skills and passion for the nursing profession.

Let the INF be the recipient of your talents. Let the INF help you establish your leadership abilities. Be a part of the INF team of volunteers to help honor and support IL nurses. Share your talents and a little of your time. Now is the time to contact the INF to help us further develop the nursing profession and to transform healthcare in Illinois.

ANA PRESIDENT'S MESSAGE

By Dan Fraczkowski MSN, RN-BC

Dan Fraczkowski MSN, RN

Greetings

On behalf of the Board of Directors and staff here at ANA-Illinois, we hope that you had a wonderful Nurses Week.

Consents to serve are now open for the ANA-Illinois Board of Directors. Consider running for a board position to help lead the work of the association and serve as the voice for nursing in Illinois. Consents to serve must be completed online at www.ana-illinois.org by **Friday, June 28, 2019**. More importantly, we hope that you participate in the election process by voting online in the fall. Please watch your email for your official online ballot in September, with online voting open from September 26 thru October 1, 2019.

Poorly chosen comments a few months ago by a Washington state legislator about nurses "playing cards" illustrate the vigilant role we must play to inform elected officials about the real work of nurses. Summer offers several opportunities for constituents to get to know their elected officials in more relaxed settings. Often state legislators will attend or march in Fourth of July parades and ask for volunteer participation. Alternatively, neighborhood festivals, block parties, and county fairs provide additional opportunities to meet elected officials. Take advantage of face time with your public officials to introduce yourself, identify that you are a Registered Nurse and share a little bit about your practice setting. Close by offering to be a legislator's healthcare expert, and continue your contact to develop a relationship over time.

As we look ahead to the 2020 general election, we will again need your help re-electing Lauren Underwood, RN from the 14th congressional district so that she can continue to serve in Washington, DC. There have already been four individuals who have declared their candidacy and are seeking to unseat Ms. Underwood. Be sure to sign up for our advocacy portal www.il-nurses.com to stay informed and participate.

With summer in full swing, I hope you can join us at one of our Healthy Nurse Healthy Nation events. Learn more about where we will be via our Healthy Nurse Healthy Nation ANA-Illinois Facebook page. For privacy reasons you must request to join the page, however, all nursing students, and nurses, members and non-members alike are welcome to participate.

Finally, I hope you can join Donna Cardillo, RN, the Inspiration Nurse, and nurses from across the state at our ANA-Illinois Professional Issues Conference on Saturday, November 2, 2019, in Springfield, Illinois. This year's theme, "Empower You" will provide strategies for you to take control of your professional career and provide 6.5 hours of CE.

Thank you for all that you do for our patients and the profession,

Sincerely,

Dan Fraczkowski MSN, RN-BC

Illinois Organization of Nurse Leaders
An affiliate of the American Organization of Nurse Executives

IONL Explores the Changing Face of Leadership

For more than 42 years, IONL has represented the interests of nurses throughout the state of Illinois. From advocacy to career development, IONL works to advance the nursing profession by improving the lives and careers of the nurses who work within it. As 2019 progresses, IONL continues to foster and develop leadership skills in nurses by introducing new educational and professional development opportunities.

Coming this fall, IONL will be hosting its premier educational event of the year, the IONL Annual Conference, September 19-20 in Oakbrook, Illinois. IONL members enjoy reduced registration rates and can save even more by registering before August 9. Titled, "The Changing Face of Leadership," the 2019 IONL Annual Conference is where nurse leaders meet, network, and explore leadership practices. This year, the conference will feature an engaging workshop, *"Civility Matters! Best Practices to Foster Healthy Work Environments*," with speaker Cynthia Clark PhD, RN, ANEF, FAAN, a renowned nurse researcher, award-winning professor, and accomplished author. Visit IONL.org for more information on registration, hotel information, and our renowned keynote speaker.

IONL now offers new, exciting pre-conference tracks held in conjunction with our Annual Conference. These full-day events include the Finance Workshop, the Midwest Institute for Healthcare Leadership, and the Aspiring Nurse Leaders Workshop designed for nurse leaders of all levels. Get the most out of the IONL Annual Conference by adding one of our Pre-Conference Workshops to your overall registration.

IONL education also includes the new online Digital Library, offering CE courses to both individuals and organizations. The Digital Library will keep you and your colleagues updated on pressing nursing challenges like workplace safety, leadership, and more. With an annual subscription to IONL's Digital Library, you can choose between an organizational or an individual subscription and receive an entire year of unlimited access to over 30 on-demand, CE webinars.

To learn more about how IONL supports the careers and fosters the leadership skills of nurses in Illinois visit www.ionl.org.

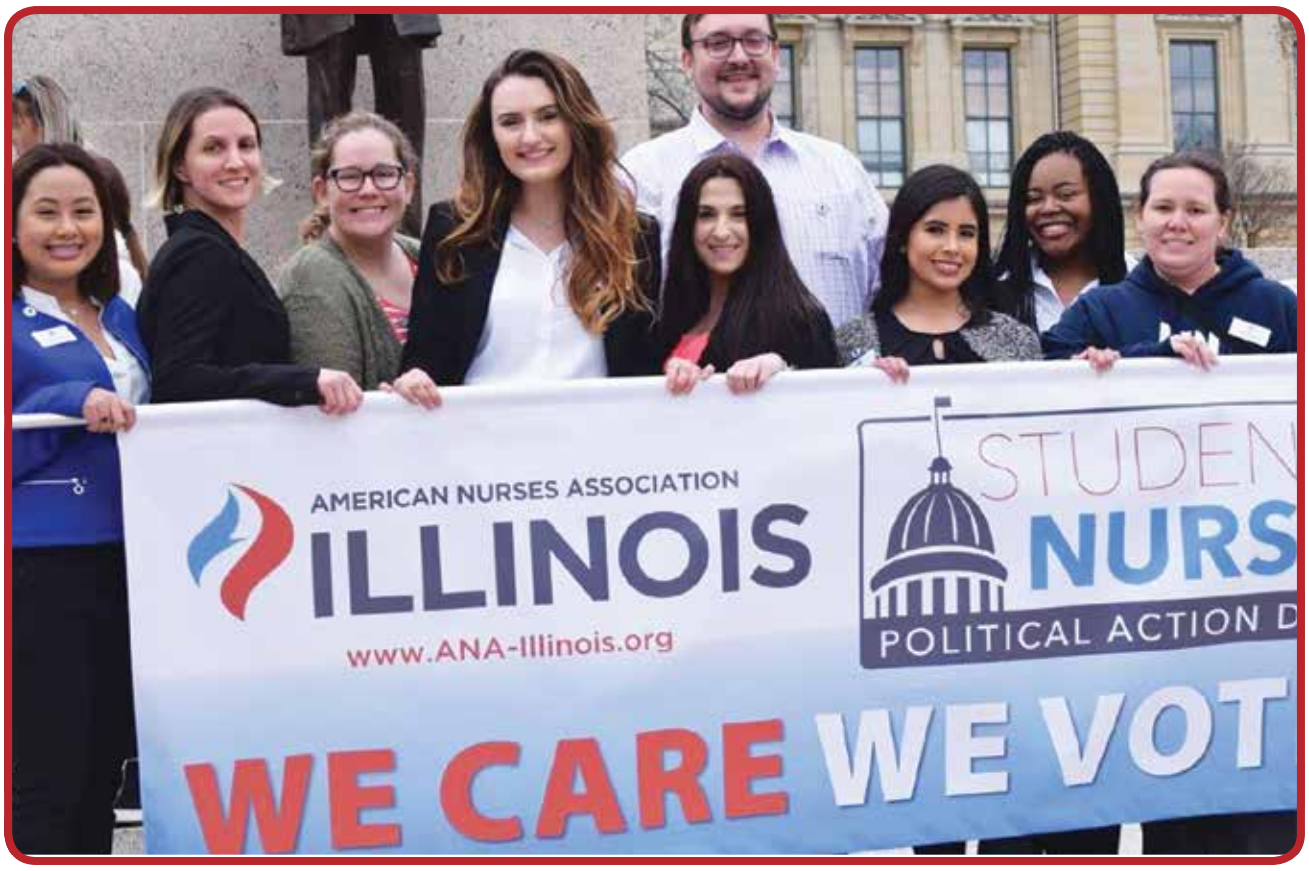
Student Nurse Political Action Day 2019

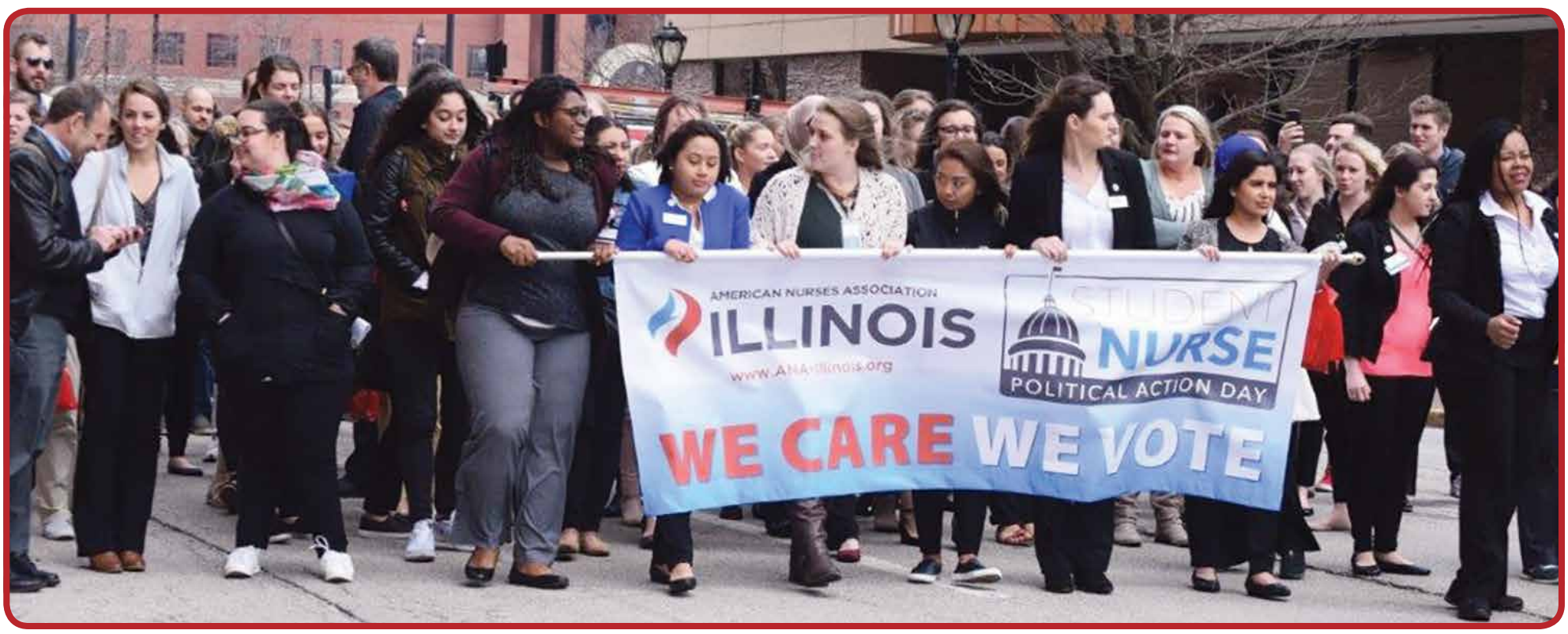
SNPAD 2019 continued from page 1

- Robert Morris University
- Rush University
- Sauk Valley Community College
- Southern Illinois University Edwardsville
- Saint Anthony College of Nursing
- St. John's College
- Saint Xavier University
- Trinity Christian College
- University of Chicago College of Nursing
- Western Illinois University School of Nursing
- Waubonsee Community College
- Wright College

Exhibitors included:

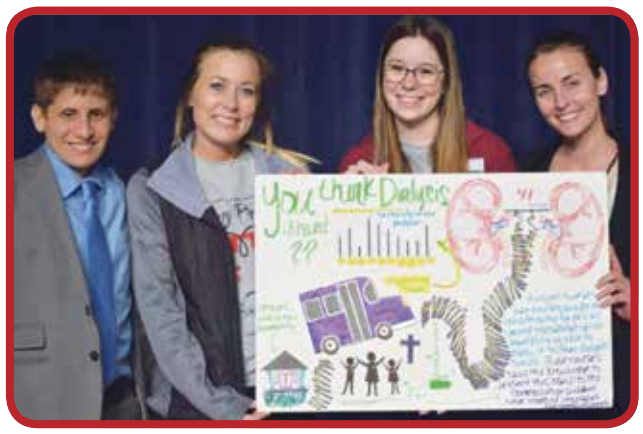
- Blessing-Rieman College of Nursing & Health Sciences
- Chamberlain University
- DDNA
- Eastern Illinois University
- Grand Canyon University
- Healthcare Associates Credit Union
- Hurst Review Sciences
- Illinois College
- Illinois DocAssist
- Illinois ENA State Council
- Illinois Nursing Workforce Center
- Illinois Public Health Association
- Illinois State University, Mennonite College of Nursing
- Indiana Wesleyan University
- Memorial Healthcare System
- Millikin University
- Northern Kentucky University
- Olivet Nazarene University
- Purdue Northwest University
- Rasmussen College
- Saint Xavier University
- Student Nurses Association of Illinois
- University of Michigan School of Nursing
- University of Phoenix





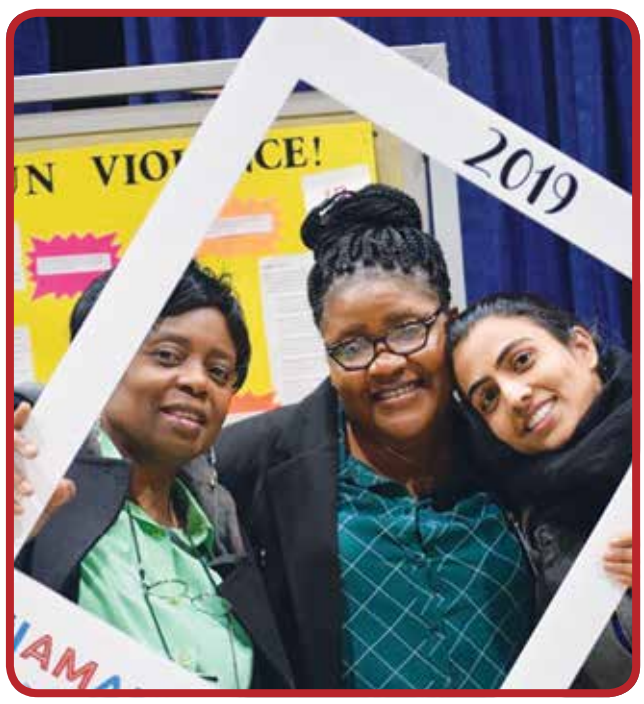
Student Nurse Political Action Day 2019

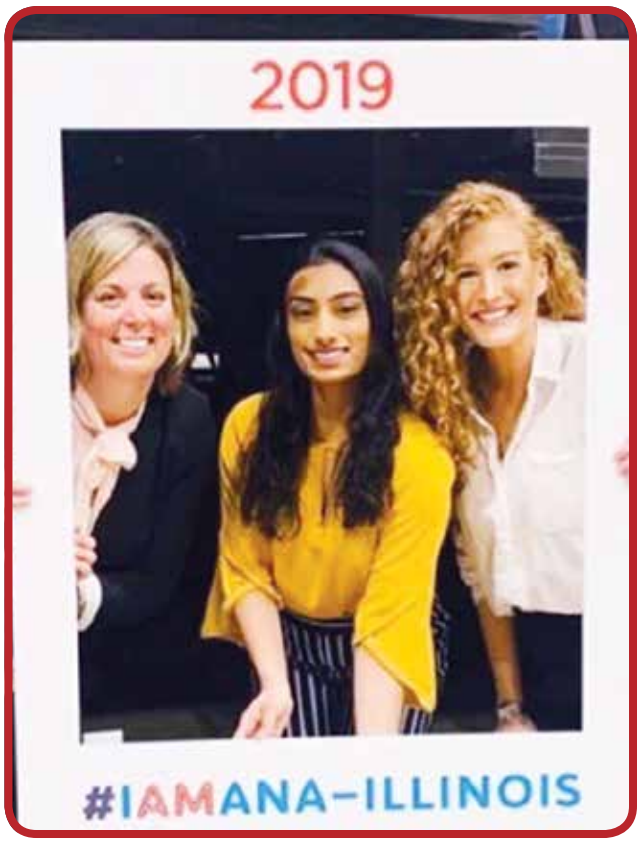
Student Nurse Political Action Day Photo Contest Winner, Shannon Fore



Student Nurse Political Action Day Poster Contest Winners Alana Austin, Nicole Wulfe, Emily Shearer

2nd place winners from Millikin University





EVERYDAY HEROES IN HEALTHCARE

HONOR A NURSE

Donate and honor a nurse who has inspired you, mentored you, fought for the advancement of the profession, stood by you, or who deserves recognition for their commitment to their patients and the work nurses do every day.

With a $25 donation, the Honoree will be listed on the INF website, in the December issue of the *Nursing Voice* and will also be entered as a nominee for the "Nurse of the Year" award* which will be awarded during the Illinois Nurses Foundation December Holiday event.

NURSES HONORED IN 2018 BY THEIR PEERS

Donna Plonczynski

Jennifer M. Grenier

Gloria Simon

Mildred Taylor

Mary Lebold

Lauren Martin

Christine R. Durbin

Fran Vlasses

Mary M. Lebold

Illinois Consortium Publication

Under the direction of Michelle Bromberg, MSN, RN (Nursing Coordinator IDFPR/Division of Professional Regulation) and Linda B. Roberts, MSN (RN Manager, Illinois Nursing Workforce Center IDFPR/Division of Professional Regulation) an Illinois Consortium of Nursing PreLicensure Simulation Educators was formed to create a digitally connected network of nursing educators with a focus on simulation and its curriculum integration. This online network coordinated by Barbara Gawron, RN, DNP, CNE, CHSE (Nursing Simulation and Learning Resource Director from Saint Xavier University, Chicago) met twice using an online platform for synchronous meetings. The following is a summary of these two meetings.

The information/resources provided at these meetings was shared by more than 30 participants from the Illinois Pre-Licensure Nursing Programs. During the first meeting in October 2018 the Consortium discussed the importance of reviewing the simulation resources on the il.nursing.gov site: http://nursing.illinois.gov/simulation.asp. These documents are the foundation for creating a successful nursing pre-licensure simulation program. The objectives covered during this first networking Zoom session included:

- Discuss the utilization of the 2015 NCSBN Simulation Guidelines for Prelicensure Nursing Programs in developing evidence-based simulation programs for undergraduate pre-licensure nursing curriculum.
- Review the Program Preparation Checklist detailed in this document.
- Demonstrate the use of an online educational platform to organize this information.

This 50 minute presentation ended with and open question forum and collaboration/suggestions from other nursing educators.

The second meeting held this past March again hosted through Zoom included 28 participants. The focus of this meeting was "Organizing Assessment and Evaluation Data from Simulation Based Learning Experiences" The objectives for this meeting included:

- Discuss methods for evaluating scenarios, facilitators, learners & program, Review 2016 - INACSL Standards of Best Practice: Simulations,
- Describe methods for organizing simulation based learning experiences in a nursing program.

This session was cohosted with Carol Kostovich, PhD, RN, CHSE (Associate Dean for Simulation-Based Teaching and Learning Marcella Niehoff School of Nursing Loyola University Chicago). The two simulation experts shared their methods and provided examples of evaluation/assessment tools and methods for reporting outcomes. For further information please send an email to gawron@sxu.edu.

EDITOR'S NOTE

In the March issue, we published an article regarding the 2018 Nurse of the Year with errors. We regret the error and apologize for the misprint. In the spirit of our mission we are reprinting the article and again congratulate Ms. Kelly on her achievements.

The 2018 Nurse of the Year award was then presented to Mary Kelly. The story submitted to honor her read:

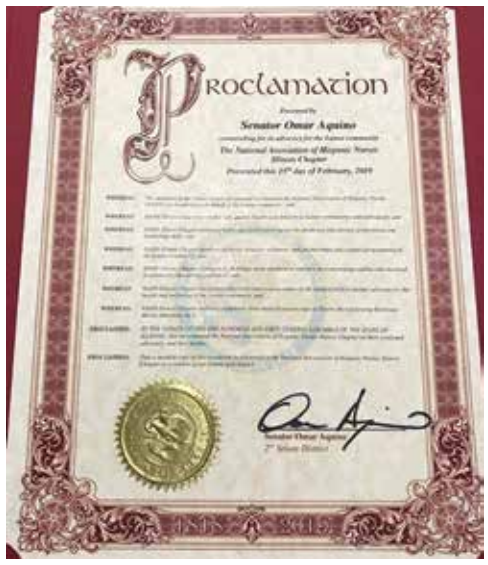
"Mary Kelly, BS, RN is a Certified Neuroscience Registered Nurse whose focus and passion is expert and timely care of the patient experiencing a stroke. Her background in nursing includes critical care and neuroscience nursing. Prior to studying nursing, she began a business career in accounting. She is currently a Disease-Specific Care Reviewer for The Joint Commission.

In that capacity, she participates in and leads Comprehensive and Primary Stroke & Traumatic Brain Injury reviews of stroke centers across the nation. She has helped to develop reviewer tools and precepts new reviewers in this role.

Past positions have included the Director of Stroke Network Operations for a major health system in the Chicago area and Stroke Program Coordinator for a major suburban acute care hospital and trauma center. She applied her business and nursing backgrounds as a Practice Manager to initiate, develop, and manage a suburban neurosurgical practice of MDs and an APRN where she was responsible for daily clinical and financial operations, interfaced with two hospital systems for clinical services, managed staff at three physical locations, communicated with law firms for litigation and expert witness services. She has also been a critical care staff RN at suburban acute care trauma hospitals. Throughout her career trajectory she has developed expertise in TJC/CMS Standards, Organizational Development, Shared Governance, Quality Improvement, Fiscal Planning, and Critical Care.

She is a member of the American Heart/Stroke Association and reviews abstracts for the International Stroke Conference. She is a member of the American Association of Neurological Nurses and served on the steering committee to develop new Stroke Nurse Certification. She is a Founding Member of the Midwest Stroke Action Alliance & past facilitator of Midwest stroke coordinators and supporting networks."

Susana Gonzalez MHA, MSN, RN, CNML
Immediate Past-President
National Association of Hispanic Nurses-Illinois



National Association of Hispanic Nurses NAHN-Illinois Chapter continues to work hard to provide quality health care and resources to Hispanic communities, increase the pipeline of Hispanic nurses, engage in policy & advocacy efforts to advance the nursing profession, and help support our members to become nurse leaders. Our chapter's growth and success has grown exponentially because of our dedicated and passionate members who see the value and impact of our organization.

Each year NAHN-Illinois has their annual Wear RED event where funds are raised to help support our student members and registered nurses seeking higher learning with scholarships, On February 15th, 2019, we had the honor of having a Proclamation read and given to the leadership by State Senator Omar Aquino of the second legislative district.

It is an esteemed honor and privilege to have received such an amazing tribute and Proclamation from the Senator.

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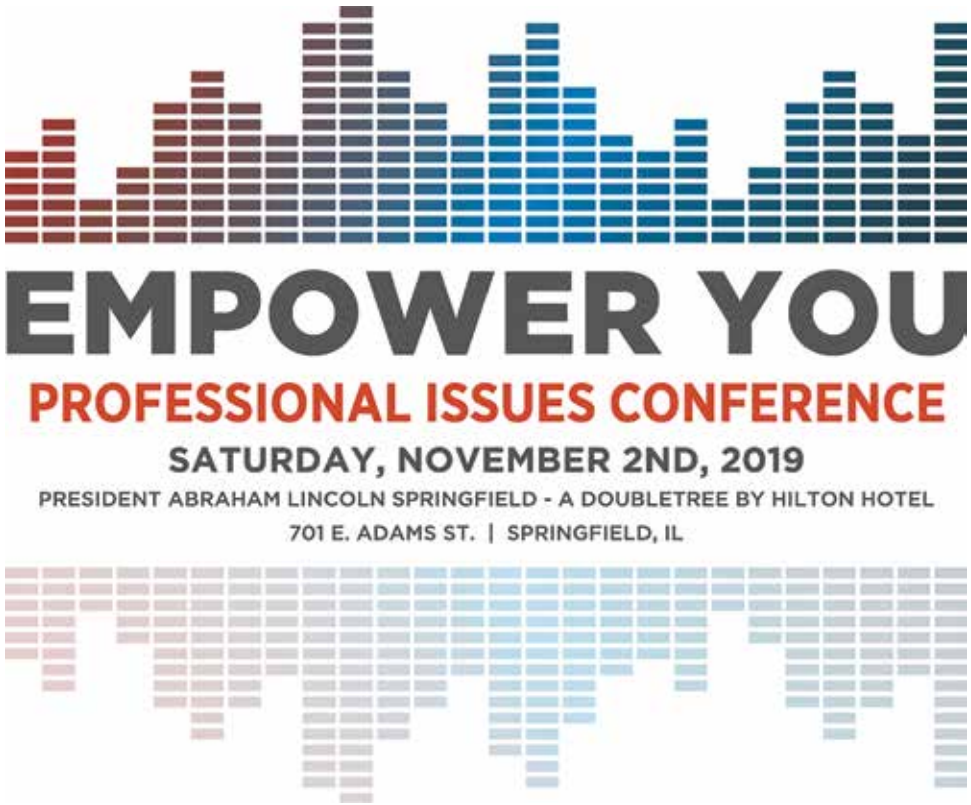
Call for Article Submission

Submit your article or research for publication in the Illinois Nurses Foundation (INF) quarterly print publication. The Nursing Voice is mailed to all 195,000+ RNs in the state. The INF and ANA-Illinois welcome the submission of nursing and health-related news items and original articles. We encourage short summaries and brief abstracts for research or scholarly contributions with an emphasis on application. To promote inclusion of submitted articles, please review the Article guidelines available on the INF website and can be downloaded at http://bit.ly/NursingVoiceGuidelines. An "article for reprint" may be considered if accompanied by written permission from the author and/or publisher as needed. Authors do not need to be ANA-Illinois members. Submission of articles constitutes agreement to allow changes made by editorial staff and publishers. See Article Guidelines for more information. Submit your articles to syswart@ana-illinois.org.



REGISTRATION OPEN

The ANA-Illinois is proud to present the 2019 Professional Issues Conference. This year's focus is Nurse Empowerment.

Empowerment can be defined as the process of becoming stronger and more confident, especially in controlling one's life and claiming one's rights. Empowerment isn't something to be bestowed, not a privilege, but a professional necessity. Join us in Springfield as we explore the meaning of nurse empowerment.

6.5 hrs CE
Registration available on our website under events – www.ana-illinois.org

KEYNOTE SESSION - NURSING: THE FUTURE IS OURS!

Nursing and healthcare stand at the precipice of radical change. As such, a unique opportunity presents itself for us to take on a larger and more pivotal role in healthcare beyond anything that most of us could have ever imagined. As this new role takes shape, nurses will need to change their way of seeing themselves, their profession, and their capabilities. It's time to stop whining and start owning our power!

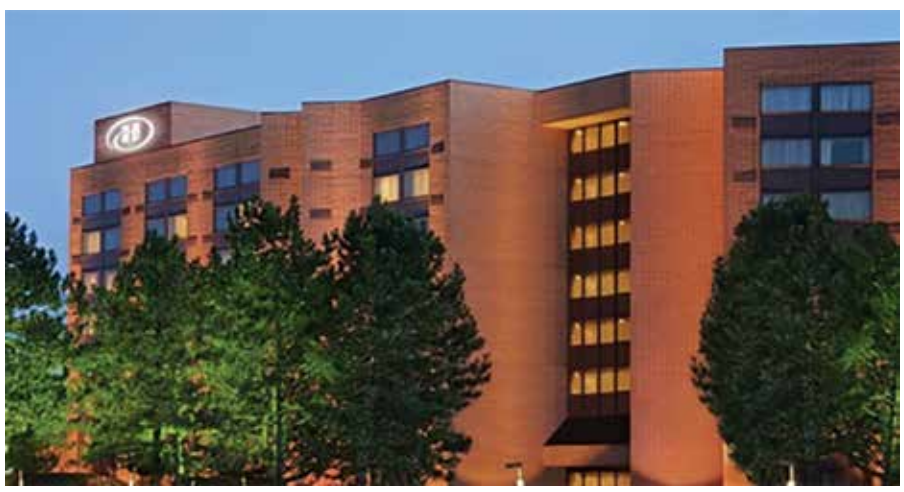
Participants will learn:

- What's in store for the healthcare delivery system over the next 20 years
- Why nursing must reinvent itself
- How nursing will evolve into a 'superpower' in healthcare
- Which behaviors, mindsets, and patterns no longer serve us
- How to get in shape to meet the challenges – and opportunities – of the future

Full program agenda is forthcoming.

Hotel Information

The 2019 Professional Issues Conference will take place at the President Abraham Lincoln - A Doubletree by Hilton Hotel in Springfield, Illinois. ANA-Illinois has secured a discounted group rate of $109/night. Reservations should be made by October 18, 2019. The special room rate will be available until the deadline or the group block is sold out.



This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

Self-Advocacy Skills for Nurses: Dealing with Incivility, Bullying and Workplace Violence: Part II

Karen Kelly, EdD, RN, NEA-BC
Ann O'Sullivan, MSN, RN, CNE, NE-BC, ANEF

Objectives

Determine causes and effects of verbal violence and bullying.
Demonstrate strategies to respond to verbal violence.
Identify resources to use in the workplace to reduce verbal violence.

This continuing education article is the second in a two-part series on *Dealing with Incivility, Bullying and Workplace Violence*. Part 1, published in the April edition of *The Nursing Voice*, discussed the definition, causes, prevalence, costs and effects of incivility, bullying and workplace violence. Part 2 focuses on strategies and resources to respond to and reduce workplace violence.

A Look at Incivility

Incivility is not a modern phenomenon. Renaissance painters, in the 15th and 16th centuries, were known for ridiculing their competitors and others by painting the faces of such people on animals or placing their likenesses in unflattering situations in their paintings, not unlike today's political/editorial cartoonists.

Incivility has expanded into various forms of workplace violence during recent decades in health care settings and other venues. The Joint Commission incorporated leadership standards that mandate the prevention of workplace violence nearly a decade ago and now offers hospitals and other healthcare organizations resources on stopping workplace violence (Joint Commission, 2012, 2019). The leadership standards note:

> **Joint Commission Standard LD.03.01.01** Leaders create and maintain a culture of safety and quality throughout the (organization).
> A4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
> A5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.
> (Applicable to ambulatory care, critical access hospital, home care, hospital, laboratory, long-term care, Medicare-Medicaid, certification-based long-term care, and office-based surgery programs and behavioral health care programs.) (ANA, 2017c)

The problem in Illinois became severe enough to engage members of the Illinois General Assembly. Illinois passed a law in 2005 that mandated hospitals report violent injuries. Few are reported because, as of fall 2017, there is no reporting software. Trauma centers must report online; other hospitals with emergency departments, free-standing surgery centers, and free-standing emergency departments can report via a paper format (Illinois Department of Public Health, 2005; WGN-TV, 2017). Illinois law requires employers to provide violence prevention programs for employees and established penalties for violence against nurses in the conduct of the nursing duties (ANA, 2017c).

The American Nurses Association (ANA) has a wealth of information on incivility, bullying, and workplace violence (WPV). Experts have come together to develop a position paper (ANA, 2015) to provide information and support for nurses and their employers to minimize the emotional, physical, and economic impact of incivility, bullying, and WPV. Other sources of information are available on the ANA website (nursingworld.org) but some documents and webpages are only available to ANA members.

Defining Incivility, Bullying, and Assault

Incivility is characterized by incidents of behavior that are rude and disrespectful. Body language, tone of voice, gestures, and facial expressions may express incivility. Gossip, sarcasm, and ignoring or actively excluding colleagues are common forms of incivility. Bullying is a pattern of behavior that reflects incivility, is aimed at a person or group of individuals (e.g., a group of new graduates in orientation), and is evident over time (Thompson, 2019). Assault may occur in both bullying and incivility.

One in four nurses has been assaulted at work (ANA, 2017b); this author was the target of a sexual assault by a physician as a new graduate in the 1970s. The definition of assault varies by jurisdiction, but generally falls into one of these categories:

1. Intentionally putting another person in reasonable apprehension of an imminent harmful or offensive contact. Intent to cause physical injury is not required, and physical injury does not need to result. Assault is defined in tort law and the criminal statutes of some states.
2. With the intent to cause physical injury, making another person reasonably fear an imminent harmful or offensive contact, essentially, an attempted battery. This definition is included in the criminal statutes of some states.
3. With the intent to cause physical injury, actually causing such injury to another person is assault. Essentially, this is the same as a battery. This is the definition in the criminal statutes of some states, and so understood in popular usage. (Cornell University School of Law, 2017).

Self-Advocacy in the Face of Incivility, Bullying, & Workplace Violence

To advocate successfully for those entrusted to our care (including patients, families, populations, communities, employees, and students), nurses must first advocate for themselves. There is a significant body of literature on the sources, causes, and theoretical models of workplace violence (WPV). Less is written about what to do in the moment incivility, bullying, and WPV occur. In an era of #MeToo and #EnoughIsEnough, nurses must speak up and act to stop incivility, bullying, and WPV, to include sexual harassment/abuse.

Nurses need to confront all incivility, bullying, and WPV assertively; demand action from employer, and take action to protect themselves. Actions should include:

- Knowing organizational policies and procedures related to incivility, bullying, and WPV;
- Filing institutional reports related to such events; and
- Knowing when to contact law enforcement, the EEOC, state regulators/licensing boards, and/or a lawyer.

As noted in Part 1 of this program on WPV, incivility, bullying, and WPV go by many names and manifest in many forms:

- Behaviors undermining a culture of safety;
- Workplace conflict;
- Lateral/horizontal violence;
- Workplace abuse;
- Bullying;
- Mobbing;
- Incivility;
- Disruptive behavior;
- Nurses eat their young; and
- Assault (added to Part 2).

Horizontal violence focuses on peer to peer incivility/bullying/WPV. Vertical violence generally focuses on the differences on the organizational ladder, for example: manager vs. employee; administrative/executive role vs. frontline manager or staff; or physician vs. nurse.

Nurses need to take a reality check of their own behavior for signs and symptoms of incivility: tone of voice, facial expressions, language used, sarcasm vs. humor, hostile/threatening gestures and postures. (ANA, 2015; Thompson, 2019). Nurses can be compassionate and caring in one moment, cruel and uncaring in their next interaction. A critical look at one's own behavior and seeking feedback from others in one's work group can help nurses determine if they demonstrate any forms of incivility. If one's self-assessment and/or the feedback of others indicate that the nurse may demonstrate uncivil behavior, seeking professional support to facilitate behavior change may be necessary. For some, discussions with feedback from a trusted mentor may enable a nurse to change uncivil behavior (Thompson).

The American Nurses Association (ANA, 2017a) offers recommendations for primary prevention of incivility in "Best Civility Practices for Nurses."

1. Use clear verbal & nonverbal communication.
2. Treat others with respect, dignity, collegiality.
3. Think about how one's words and actions affect others.
4. No gossip, no rumors.
5. Stick to the facts, not conjecture.
6. Collaborate with others and share information as appropriate.
7. Offer to assist others but accept refusal gracefully.
8. Take responsibility for one's actions.
9. Recognize that abuse of power/authority is never acceptable.
10. Speak directly to the person with whom one has an issue; no end-runs.

11. Be open to other's point of view, experience, and ideas.
12. Be polite & respectful; make apologies when indicated.
13. Encourage, support, & mentor others.
14. Listen to others with interest and respect.
15. Aspire to uphold the ANA Code of Ethics, which is noted in the Illinois Nurse Practice Act 2018 (225ILCS 65/60-35) as a standard of RN practice.

Civility is the result of integrating these basic communication skills and professional behaviors into everyday nursing practice. These skills and behaviors are essential to professional nursing practice in any nursing role (e.g., staff nurse, advanced practice registered nurse, manager/executive, researcher, educator) and in any workplace, including clinical settings and academia (ANA, 2017a).

Nurses and others working in health care organizations, as well as in academia for nurse educators, may have difficulty in reporting incidents of WPV:

- Incidents go unreported out of fear (e.g., reprisals, blame) and misperceptions and shortcomings of the healthcare culture (e.g., workplace violence is part of the job).
- Lack of clear organizational and government standards for reporting WPV.
- Lack of agreement about what is WPV (e.g., does it include verbal harassment?) (ANA, 2015).

These issues lead to problems in primary, secondary, & tertiary prevention of WPV (ANA, 2015). Assertive communication skills offer one approach to primary prevention of incivility, bullying, and WPV.

Assertive Communication Skills: Primary Prevention

Assertiveness training was a product of the women's movement in the late 1960s into the 1970s. Such skills training was integrated into some nursing curricula during that era (Chenevert, 1988; Grohar-Murray & Langan, 2011).

Assertive communication focuses on:

- Verbal skills;
- Facial expression;
- Eye contact;
- Posture, position, and movement;
- Gestures; and
- Tone of voice/pace of speech.

Behaviors that denote a lack of assertiveness, self-confidence, and self-control:

- Lack of appropriate eye contact, looking down or away;
- Soft or whining voice, rapid speech, quiver in one's voice, hesitancy when speaking;
- Shaking or shivering, slumping posture ("getting small"), swaying.

Assertiveness is not aggression. Assertiveness seeks to prevent or stop verbal and/or physical aggression. Assertiveness allows one to act in her/his own interests without violating the rights of others or treating others with disrespect. It is characterized by certain cognitive processes:

- Active listening, not just hearing the other person (neurological processes), to include reflecting/paraphrasing the other's ideas and feelings.
- Stating your position/feelings/perceptions clearly without accusations.
- Exploring possible solutions, evaluating pros and cons.
- Consider the role that cultural differences may play in a situation, with misinterpretation of cues/behaviors.

Behavioral skills that reflect assertive communication skills include:

- Relaxed posture, position;
- Facial expressions that are friendly or neutral, as appropriate;
- Maintain appropriate space between you and the other person;
- Appropriate gestures, minimal gestures;
- Appropriate eye contact (no staring!);
- Attentiveness;
- Well-modulated voice, calm speech, moderate flow of speech, moderate volume; and
- Practicing verbal skills outside of workplace: rehearsal!

Assertive verbal skills include:

1. Learn to say "no" graciously, politely, firmly, without making excuses.
2. Be a broken record: repeating your position/need/response without anger.
3. Self-disclosure and "I statements" to give information about you: "I have worked here for 10 years" or "I need you to stop calling me names so that we can work together."
4. Agree with the aggressor on even the smallest truth or point of agreement.
5. Seek a workable compromise.
6. Use "fogging" by accepting valid criticisms of yourself and move on with the discussion (Chenevert, 1988; Grohar-Murray & Langan, 2011).

When working with people, including colleagues, patients, and family members, who may have exhibited uncivil behavior to you or others in the past, make sure you position yourself in a room or hallway, so you have access to a quick exit if the other person(s) shows early signs of aggression or other uncivil behavior.

Responding to WPV as It Happens: Secondary Prevention

- Address the aggressor directly, immediately, and in private, when possible.
- Use your work group's code word to gain a witness or witnesses or to get help/security/access to an exit.
- Report the event, verbally and in writing, following the organizational policies and procedures.
- Take personal notes to document the event for your own records for later recall and/or to document events to establish a pattern of behavior.
- If verbal violence is escalating, offer the aggressor some time to organize his/her thoughts and get away.

If the WPV becomes physical:

- Get out as quickly as possible.
- If necessary, yell; push, pull, punch; use elbows, knees, or feet to distract the aggressor.

Responding to the Aftermath of WPV: Tertiary Prevention

- Unless the perpetrator has been declared incompetent by the courts, the perpetrator is responsible for her/his behavior.
- Hold the perpetrator responsible: implement organizational procedures; notify the police; EEOC (sexual harassment); accrediting bodies (when organizational policies fail); regulatory & licensing bodies; and/or an attorney.

Witness to WPV Against a Colleague? Be an Advocate!

- Speak up, speak out.
- Aid the colleague to get out of the immediate situation, physically and/or emotionally.
- Address the incivility of the perpetrator, but with civility!
- Record your observations of the event.
- Provide peer support to the target/victim.
- Respond openly and honestly in any institutional or legal proceedings related to the WPV.
- Take Action by Joining Nurses Across the Country (ANA, 2017b): go to http://p2a.co/t84cVfR to take the pledge. You can also text "PLEDGE" to 52886. (ANA, 2015, 2017a, 2017c).

CE Offering
1.0 Contact Hours
This offering expires in 2 years:
February 25, 2021

Learner Outcome:

80% of those reading the article and completing the post-test, the nurse will be able to describe the causes and effects of workplace violence, use effective strategies to respond to workplace violence and identify one or more resources to use to reduce violence in the workplace.

HOW TO EARN
CONTINUING EDUCATION CREDIT
This course is 1.0 Contact Hours

1. Read the Continuing Education Article
2. Go to https://www.surveymonkey.com/r/22192 to complete the test and evaluation. This link is also available on the INF website www.illinoisnurses.foundation under programs.
3. Submit payment online.
4. After the test is graded, the CE certificate will be emailed to you.

HARD COPY TEST MAY BE DOWNLOADED via the INF website www.illinoisnurses.foundation under programs

DEADLINE
TEST AND EVALUATION MUST BE COMPLETED BY February 25, 2021

Complete online payment of processing fee as follows:
ANA-Illinois members- $8.00
Nonmembers- $15.00

ACHIEVEMENT

To earn 1.0 contact hours of continuing education, you must achieve a score of 80%

If you do not pass the test, you may take it again at no additional charge

Certificates indicating successful completion of this offering will be emailed to you.

The planners and faculty have declared no conflict of interest.

ACCREDITATION

This continuing nursing education activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

CE quiz, evaluation, and payment are available online at https://www.surveymonkey.com/r/22192 or via the INF website www.illinoisnurses.foundation under programs.

Implementation of a Perioperative Blood Utilization Protocol

by Marissa S. Marshall
Advisors - Dr. Lori Sprenger PhD RN CLNC and Yvette Saba MBA MSN RN

This project is designed to help create and implement a perioperative blood management protocol in the perioperative setting. Transfusion guidelines are intended to improve clinical outcomes and may decrease the number of transfusions that are not clinically indicated for the operative patient. The guidelines are not intended to be requirements but should serve as a guide for practitioners.

Background of Project and Assessment

Blood utilization is a current issue in healthcare organizations because of the risks and cost associated with transfusion reaction complications. One way to improve patient safety and outcomes is by standardizing practice, establishing guidelines, and providing education to healthcare providers.

Blood Management

Perioperative blood utilization is used to manage both preoperative and intraoperative patients dealing with bleeding and anemia. The administration of blood products including packed red blood cells (RBCs), fresh frozen plasma (FFP), and cryoprecipitate carry patient risks. Carson, et al. (2016) describe risks associated with transfusions to be both transfusion-transmitted infections and noninfectious adverse events such as transfusion-related acute lung injury and transfusion-associated circulatory overload. While the risk of contracting an infection from an infected blood transfusion is low, there is greater risk when receiving a transfusion because the body's immune system is more susceptible to reacting to substances in the donor's blood (Torhan, 2014).

Problem

Current practice at this facility does not include any guidelines or suggestions for when a transfusion is appropriate or needed. Current practice is solely driven on clinical picture and anesthesia or surgeon request. Recent Joint Commission surveyors have suggested the use of guidelines or protocols to standardize care surrounding blood management, specifically restrictive RBC transfusion strategies and providing education to the risks of transfusions (Jenkins, Doucet, Clay, Kopko, Fipps, Hemmen, & Paulson, 2017).

Rationale for Focus

Creating a blood management program identifies expectations and guidelines for clinicians to use as a guide when deciding if a transfusion is appropriate for the patient. According to Quality and Safety Education for Nurses (2018), these guidelines will create collaboration and teamwork, both QSEN competencies, within the perioperative setting. The surgeon, anesthesia, perfusion, and perioperative nurses will collaborate to ensure effective communication regarding the patient's necessity for the transfusion. Each member of the operating room team functions with autonomy. Each member has a responsibility to ensure proper testing, history, and the overall clinical picture has been assessed prior to surgery as well as transfusing. Using evidence-based practice to create the practice guidelines may result in a decrease in transfusions, fewer complications, and a decreased length of stay.

It is important to discuss the patient's wish regarding blood administration. Some religions prohibit the use of blood products but may find the use of autologous blood acceptable within a closed circuit such as cellsaver. An open discussion about the patient's belief system regarding blood is one example of whole person nursing theory. Whole person nursing emphasizes the importance of treating mind, body, and spirit instead of treating a condition (PracticalNursing.org, n.d.).

Theoretical Framework

Madeline Leininger's Transcultural Nursing Theory acknowledges the need for a balance between scientific and humanistic interactions. The relationship between nurse and patient involves an understanding of the patient's cultural beliefs, values, and practices. Creating full awareness of the patients' belief system and practices allows clinicians to provide respectful and beneficial care. Beliefs and practices provide the patient with the independence to choose to maintain or regain well-being. Transcultural nursing theory also promotes relationship-based care (Petiprin, 2016).

Whole Person Nursing

The nurse plays an important role in creating a trusting relationship with the patient and family. During the preadmission and pre-operative phases of care, the nurse develops rapport with the patient and family by educating and discussing the plan of care for the upcoming procedure. Questions and dialogue regarding the patient's beliefs, preferences, and environment are encouraged between all parties. It is imperative the operative team have a solid understanding of the patient's belief system and what the patient's role is within the family and community. Once the patient is sedated it becomes the nurses' responsibility to make the best decisions for the patient. Whole person nursing concepts include clinical judgement, critical thinking, nursing, and communication (L. Sprenger, personal communication, February 8, 2019). Each of these concepts is especially important in the intra-operative phase while coordinating care with the perfusionist, the surgeon, and the anesthesiologist.

Plan to Address Issue

Guidelines for the blood management program will be created using evidence from the scholarly literature and input from the chief of cardiac surgery, chief of cardiac anesthesia, the president of the anesthesia group, the medical director of the blood bank, and

nursing's surgical practice council. Some guidelines that are needed include:

- creating a hemoglobin threshold for transfusing
- suggesting adjunctive therapies
- assessing for bleeding risks and anemia preoperatively
- ensure the length of time blood is stored.

Outcomes

Outcomes for this project included standardization of patient care partnered with better patient outcomes exhibited by a reduction in transfusions and decreased length of stay. A comparison of total number of blood components given pre-implementation versus post-implementation was performed. The total number of patients receiving blood or blood components was examined also. Additional information about these patients was reviewed to identify trends or areas of improvement. Long term outcomes include the identification of comorbidities, inpatient versus outpatient status, use of blood thinning medications, and the amount of time between withholding the medication and the time of the procedure. Identifying trends or patient populations that need additional improvements will lead to new guidelines or interventions.

Summary of Literature Review

Collectively, the research supports implementation of a restrictive approach to RBC transfusion for perioperative patients because it decreases the patient's risk of exposure to blood-borne pathogens, without compromising oxygenation of vital organs due to low hemoglobin. A discrepancy lies in the length of time a unit of RBC's should be stored before use. More recent research showed that patients that received standard-issued blood, stored up to 35 days, experienced no great risk of adverse events than those patients that received blood stored for a maximum of 21 days (Carson, et al., 2016). Additional research should be conducted on some pre-procedure and pre-admission guidelines. Optimizing patients for elective surgeries could prevent more blood transfusions.

Results

Both qualitative and quantitative outcomes were measured to assess the need and effectiveness of the guidelines. Pre-implementation qualitative data provided valuable information about gaps in education or awareness, as well as supported the need for standardization. Quantitative data gave support to the effectiveness of standardization and identification of areas for additional research and changes.

Quantitative Results

	Pre-implementation (January)	Post-implementation (March)
Number of pts transfused	18	15
Number of products given	86	60
Percentage of patients transfused	15.7	13.1
Average length of stay	19.2	14.2

The percentage of patients receiving transfusions one month prior to implementation was 15.7. The post-implementation percentage showed a positive decline at 13.1. The number of patients receiving blood declined slightly from 18 down to 15. The total number of blood products administered pre implementation was 86 and post implementation was an impressive 60. The average length of stay in the month of January was 19.2 and declined in March to 14.2.

Qualitative Results

Qualitative data collection assessed the anesthesiologists' levels of comfort with the current practice for blood management. Perceptions identified were the overall need for standardization, physicians were practicing differently, but welcomed guidance. Additionally, a variety of hemoglobin thresholds in varying patient populations were identified.

Follow up at one-month post implementation evaluated the guidelines and identified barriers. Overall, results showed the protocol was easy to understand and follow. Anesthesiologists felt the largest barrier was to surgeon's preference or subjective perceptions of bleeding.

Discussion of Outcomes

The goal of this study included educating perioperative staff and anesthesiologists to feel more confident deciding on optimal timing for blood or components. The protocol helped to shed light on potential overuse of blood components. Staff awareness and interest in decreasing blood utilization has been viewed as a positive outcome of the project. A limitation of the study is the short length of time. Future studies should include an extended period of study. Additional education should be provided to all anesthesiologists, vascular and thoracic surgeons. Additional research should be conducted excluding emergent procedures.

Quality and Safety Education for Nurses

Teamwork and collaboration were important throughout the improvement project. Blood utilization in the operative setting required effort from multiple disciplines. The creation and implementation of the protocol took effort from pre-admission nurses, intra-operative nurses, anesthesia, perfusion, and surgeons. The group used evidence-based practice and research to create the guidelines. A better understanding of each caregivers' role allowed the members to work more efficiently. For instance, the intra-operative nurse placed lab work orders as soon as the patient came off the heart-lung machine, to minimize the time needed to receive results.

Whole Person Nursing

Understanding a patient's belief system and asking the patient if there are any objections to receiving blood resulted in the nurse and patient engaging in more dialogue. The intra-operative nurse and anesthesiologist often conducted their pre-operative assessment together to prevent the patient unnecessary repetition. The practice allowed for additional questions to be asked regarding patient preferences and was confirmed with multiple providers at the same time. The assessment was performed with the patient's family in the room to encourage questions or concerns from all parties. Because bleeding is considered subjective in many circumstances, critical thinking, communication, and clinical judgement are imperative.

Transcultural Nursing Theory

Madeline Leininger's theory of Transcultural Nursing embraces the principles of whole person nursing. Initiating dialogue about the patient's preference and belief system opened the door to educating patients about blood utilization and how caregivers attempt to prevent transfusions. During the implementation phase one patient did refuse blood or blood products due to religious beliefs. The pre-admission nurse and surgeon confirmed the request and differentiated all types of therapies to confirm what the patient would allow. In this instance, the patient allowed autologous blood transfusion through cell salvage. Communication with the patient pre-operatively is crucial. These discussions need to begin before the patient ever enters the hospital, in order to minimize the need for transfusion and maximize outcomes.

Next Steps

Continuing to audit blood utilization is necessary for ongoing development of guidelines and clinical evaluation. Overall outcomes would look for a reduction in the percentage of transfusions and the length of stay for the perioperative patient population. Additional education with surgeons would prove beneficial, allowing for discussion and recommendations, leading to a more vested interest in blood utilization reductions. Implementation across system-wide operative services would require additional education of all perioperative nurses, surgeons, and anesthesiologists.

Summary

The implementation of a blood management protocol can standardize care leading to fewer blood products being transfused. A decrease in transfusion rates can potentially prevent unnecessary complications from blood borne pathogens and reactions. Consequently, implementation of the protocol also revealed a decrease in average length of stay for perioperative patients, which has the potential to improve patient outcomes and decrease overall cost.

ILLINOIS NURSING WORKFORCE CENTER

Guidelines for the Use of Simulation by Prelicensure Nursing Education Programs*

Nursing program faculty members maintain the flexibility of defining simulation hours as they do clinical hours and as such, simulation hours are considered equivalent to clinical hours. Just as clinical hours include a variety of activities in addition to direct patient care, such as pre-conference and post-conference, simulation hours may include time spent for pre-conferences, preparation for patient care assignments, and de-briefing.

The program is responsible for defining and evaluating achievement of program outcomes as well as for selecting and implementing teaching/learning strategies to support achievement of the outcomes. These responsibilities are within the realm of the MSN prepared faculty.

A nursing program may opt to utilize a maximum of 25% of its total program's designated clinical hours to meet learning outcomes through the use of simulation. A Registered Nurse(s) who is (are) master's prepared in nursing will serve to coordinate, conduct, and evaluate simulation-based learning experiences in all prelicensure nursing education programs.

All Illinois pre-licensure nursing programs are encouraged to follow the *National Council State Boards of Nursing (NCSBN) Simulation Guidelines for Prelicensure Nursing Programs* delineated in Alexander, Durham, Hooper, Jeffries, Goldman, Kardong-Edgren, Kesten, Spector, Tagliareni, Radtke, and Tillman (2015).

Simulation Guidelines and links to the resources listed below are available on the IDFPR/Illinois Nursing Workforce Center website http://nursing.illinois.gov/simulation.asp.

*Approved by the Illinois Department of Financial and Professional Regulation (IDFPR) Board of Nursing (2015)

Resources:

(2015) IDFPR Advisory Board Of Nursing Guidelines for the Use of Simulation by Prelicensure Nursing Programs

(2015) *Journal of Nursing Regulation 6(3) 39-42:* NCSBN Simulation Guidelines for Prelicensure Nursing Programs, M. Alexander et al

(2014) *Journal of Nursing Regulation Supplement 5(2):* The NCSBN National Simulation Study: a Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education

The Value of Post-Acute Care Coordination (PACC) in Reducing Readmissions

Colleen Morley DNP RN CMCN ACM-RN

There has been a focus on readmission reduction and prevention in acute care facilities since 2009. Potentially preventable readmissions have been related to failed or ineffective discharge planning especially for patients with chronic, high-focus diseases such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). According to CMS, the population of people diagnosed with chronic medical conditions is predicted to rise to 125 million by the year 2020 (Center for Medicare and Medicaid Services, 2012). A significant increase in this population will lead to increased spending at a time when the Medicare program itself appears to be in financial trouble. The extensive costs per hospital admission associated with CHF and COPD (to include care, medication, therapy) represents a major financial liability to health care systems; a significant component being the issue of unplanned, avoidable readmissions.

As an example of the impact, CHF patient's 30-day readmission rates are reported as high as 34%, and the cost of managing CHF in the United States is estimated to be at least $10 billion per year. The current COPD population is estimated at 12.7 million diagnosed people, and COPD 30-day readmission rates are reported to be 27% nationwide with associated costs of an estimated annual $11.9 billion in healthcare dollars and an average annual cost per beneficiary of $9,545, according to Medicare claims data. (Center for Medicare and Medicaid Services, 2017).

The factors driving the need to reduce readmissions include cost containment, the achievement of performance initiatives and penalty avoidance and improvement of quality indicators and patient experience. National awareness of adverse medical outcomes occurring within care settings continues to rise through quality data reporting, patient satisfaction reports and dedication to healthcare transparency. The expanding evidence base points to comparable problems occurring during the transitions between care settings. There is a key opportunity to develop interventions to improve the quality of patient transitions from acute care to the community with a goal of reducing readmissions.

According to the Institute for Health Improvement (2017), current research has demonstrated that the rate of readmissions can be reduced by improving discharge planning and care coordination between all levels of the care continuum concurrent with providing increased opportunities for patient coaching, education, and support for self-management. Implementation of such an intervention from time of admission through the immediate 30-day post-acute period is proposed to decrease readmissions and improve quality of care.

The focus of this project was to develop and evaluate a program providing coordinated care to reduce the readmission rate for patients with select chronic conditions. The identified objectives for the program were to provide support, resources and increased education to CHF/COPD patients from the time of inpatient admission through the immediate 30-day post-acute period to increase self-management skills to decrease 30-day readmissions for CHF/COPD patients.

The project goal was to implement a program of ongoing education and personal support in the immediate post-acute period (30-day post-hospitalization). Interventions proposed included: education on chronic condition management, ongoing telephonic support calls to review medications, signs, and symptoms, schedule/remind for follow up appointments, gap-finding for the discharge plan and providing a point of contact for patient/family questions.

The program outcomes were compared to standard post-acute follow-up (standard or 'usual' discharge instructions, basic condition management education and primary care physician (PCP) visit within seven (7) days post-hospitalization without ongoing support) to evaluate if the program's interventions resulted in a decrease CHF/COPD thirty-day readmission rate during the eight (8)-week study period.

Comprehensive care coordination models have been shown to demonstrate the most impact on reducing readmissions for the target populations. Literature reports on several programs that feature the goal of using a holistic approach to develop collaborative, interdisciplinary teams to facilitate patient self-management from time of admission through a defined post-discharge period was provided and included vital interventions currently absent from the standard discharge process. Assessment and evaluation of the patient's available social supports and the need to restructure the discharge process to eliminate fragmentation and communication breakdowns were acknowledged as top priorities. Top strategies include: consistent use of continuous medication reconciliation at each level of care, use of standardized tools and patient education across the care continuum, active coordination of follow-up appointments including making and confirming follow up appointments prior to discharge, an effective, real-time handoff to the next level of care and making contact with the patient within 48-72 hours post discharge to review and reinforce the discharge plan will increase the communication needed to effect a successful transition.

Recognized Comprehensive Case Management programs utilizing these techniques include Project BOOST (Better Outcomes for Older Adults through Safe Transitions), Project RED (Re-engineering Discharge), STAAR (State Action on Avoiding Rehospitalization), Naylor's Transitions of Care Model (TOC), Coleman's Care Transitions Interventions (CTI) and Hospital to Home (H2H) have all produced documented decreases in readmission rates by use of varied strategies. Bobay, Bahr, and Weiss (2015) note that of the 32 hospitals included in their survey, many hospitals are utilizing one of these identified transitional care models as a base but have customized their programs by combining features of other models to address their specific populations and needs.

The vision for this project was to provide patient-centric coordinated care across the continuum to assist the patient/family in overcoming the challenges of managing chronic conditions. From hospitalization to discharge and beyond, the project's mission was to assist patients in navigation of the critical initial 30-day post discharge period by actively engaging and partnering with the patient/family to provide excellent patient outcomes and experience.

The process workflow for the project was defined as follows:

INPATIENT

1. The patient was admitted with a primary or secondary diagnosis of CHF or COPD.
2. The patient was identified for inclusion in the program by daily diagnosis report or active referral from the primary nurse, physician or Case Manager RN to the Post Acute Care Coordination RN (PACC RN)
3. The PACC RN was responsible for following the identified patients from the time of identification, to include:
    a. Completion of an assessment and evaluation of the patient's available social supports
    b. providing ongoing condition management education addressing diet, lifestyle changes, medication management throughout the inpatient length of stay
    c. referral to resources for post-acute services, such as home health care, community resources, prescription assistance
    d. performing discharge teaching and providing coordinated follow-up care schedule
        i. confirmation of all follow up appointments prior to discharge and transportation arrangements, if needed
    e. providing active handoff to the next level of care by calling primary care provider and other resources with transition of care documentation

POST-ACUTE

1. The PACC RN contacted the patient within 48-72 hours post discharge via telephonic outreach to the patient to review and reinforce the discharge plan
2. The PACC RN coordinated and scheduled a series of four (4) weekly scheduled telephone appointments with the patient. Elements of these calls included:
    a. review and reinforce the discharge plan
    b. identify gaps in care and provide solutions to barriers in access to care
    c. provide the patient with an opportunity to seek clarification if needed.
3. At the successful completion of the 30-day post-acute period, the patient was discharged from the program and provided a "graduation" certificate.

The PACC RN, having established a therapeutic relationship with the patient during his/her stay, used the discharge follow up process to build upon the education previously given. This provided continuity of information, less confusion for the patient and the ability for the patient to ask more specific, personalized condition-related questions.

The implementation of this project occurred over an eight (8) week period. During weeks 1-4, the focus was on participant recruitment, PACC RN education, stakeholder education and ongoing gap identification for process improvement. The focus for weeks 5-8 was on completion of the follow-up program, ongoing evaluation of the readmission rates in real time and continued process improvement and refinement.

Over the first four weeks, patients meeting the criteria established for inclusion were recruited for participation in the project. A total of 64 patients were recruited to the project; 32 COPD patients and 32 CHF patients (figure 1.0). Of this population, there was attrition of twelve patients over the duration of the project either through active or passive withdrawal. Active withdrawal was identified as participant request to disenroll or subsequent discharge to an excluded discharge disposition (such as skilled nursing facility, long term care or hospice). Passive withdrawal was identified as failure to contact the participant through a series of three (3) call attempts on different days, at different times of the day and also included reaching out to the identified additional point of contact to re-verify contact information and potentially relay a message to the participant that the PACC RN was attempting to call for follow up. The PACC RNs identified an opportunity to make additional calls to higher risk participants; identified as participants with a history of frequent readmission or emergency department (ED) use. Increasing the frequency of the follow-up calls provided more opportunity to intervene, support & coordinate/ direct patients to PCP for care.

Project evaluation was completed by comparing pre- and post-intervention data for the target population to evaluate for reduction of actual readmissions for the target population, including observation status admissions. There can be a risk of these patients being placed in Observation status so as not to "count" as a readmission. To evaluate the true impact of the intervention, Observation readmissions were included in the data collection and were not identified as such in the data.

The intervention's success was based on lack of readmission within 30 days of discharge for the index admission of the target population member. Participants were recruited for four (4) weeks to allow for readmission to be evaluated for the target population within the eight (8) week implementation period.

Time Period	COPD Index	COPD Readmit	COPD % Readmit		CHF Index	CHF Readmit	CHF % Readmit
Aug-Sept 2017	32	6	18.75%		32	3	9.38%
June-July 2017	24	7	29.20%		41	6	14.60%
Aug-Sept 2016	20	5	25%		45	7	15.60%
Pre/Post +/-	8	-1	-10.45%		-9	-3	-5.23%
2016/2017 +/-	12	1	-6.75%		-13	-4	-6.23%

Additional review of data based on year prior (same timeframe), as well as the immediate previous eight (8) week readmission, was deemed appropriate due to the perceived "seasonality" of CHF/COPD admissions; it was determined to be applicable to measure results in real time as well as historical for like time periods.

At the end of the eight (8) week intervention period, the readmission results were compared to the like timeframe from the year prior and the immediate eight-week period prior to intervention.

Data collected included the number of patients meeting criteria who agreed to participate (broken down by CHF or COPD diagnosis) and the total readmission events within 30 days from index admission. The initial evaluation is reported as a straight forward percentage of the population experiencing readmissions and follows the guidelines set forth by Medicare for consideration. Based on the data analysis, there has been a reduction in readmissions for the implementation group versus the immediate pre-implementation group and the same time period one year prior group noted. The intervention period (Aug-Sept 2017) noted a readmission rate for COPD of 18.75% and CHF of 9.38%. Compared to the pre-implementation period (June-July 2017) readmission rates of 29.2% (COPD) and 14.6% (CHF), there was a decrease in readmissions of 10.45% for COPD and 5.23% for CHF. Likewise, the year over year comparison demonstrates a reduction in readmission rates of 6.75% for COPD and 6.23% for CHF.

The frequency of readmissions was noted to decrease over the eight (8) week implementation period. Seven (7) readmissions were noted in weeks 1-4, with two additional readmissions occurring in weeks 5-6 and no readmissions in weeks 7-8. It can be inferred that as the implementation continued and became more "hard-wired," readmissions decreased as a result. The PACC RNs reported more comfort with the role and follow-up calls as well as being encouraged by the week four evaluation showing steady decreases in their population's readmission rates.

Conclusion

The current state of the discharge process has been shown to be ineffective at successfully transitioning chronic condition patients back to the community. Evolving the discharge process from physician order, written discharge instructions accompanied by a stack of indecipherable patient education handouts and recommendations on a follow-up timeframe is necessary to serve the needs of the chronic condition management population. Moving to a true transitional process with active navigation through the immediate post-acute period will require focus on process improvement, stakeholder education and creation of an active interprofessional collaboration to provide the best support and education for each patient.

Implementing a transitional care model to reinforce the discharge education post-discharge is an effective strategy to improve patient satisfaction and decrease readmissions, as noted in the literature. Research demonstrates that interventions started in the acute facility and carried through the transition to the community for a minimum of 30-days are more effective at reducing readmissions than interventions initiated post-discharge. Furthermore, a comprehensive program that includes five or more of the transitional elements has been found to be more effective than programs including less than five components. Implementation of a post-acute follow-up intervention, utilizing elements of the established transitional care programs combined into a facility-specific model has been demonstrated to meet the needs of the patient and facility to reduce readmissions.

Case Managers are in an optimal position to develop interventional programs for effective patient transitions. These specially trained healthcare professionals are adept at developing discharge plans and accessing resources for post-acute care. With an eye to the revenue cycle, they can make an impact by helping the facility to avoid the potential financial ramifications associated with readmissions, improve patient's outcomes and achieve the patient's goals to remain in their own environment which in turn, improves patient satisfaction. Case Managers as active participants in interprofessional collaborative care models can help to break down silos, lessen the fragmentation of patient care and increase the education to the patient/caregiver throughout the acute care length of stay. Expanding the case manager/patient interaction outside the walls of the acute care facility gives a greater opportunity for success through ongoing support and aids the facility in serving their patients/community.

Free Webinar CE: Successful Academic-Practice Partnerships in Illinois Communities

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Nurse experts will share the successes and lessons learned through academic-practice collaboration in building and sustaining partnerships. Projects include the use of social media in marketing health improvement campaigns. The use of social media in evaluating campaign effectiveness. Interdisciplinary collaboration – providing education throughout a rural county. These projects are supported by a Robert Wood Johnson Foundation (RWJF) grant.

The webinar will include the role of nurses in improving the health of individuals, families, and communities by addressing social determinants of health and providing effective, efficient, equitable, and accessible care across the care continuum. Presentations will also identify the system facilitators and barriers to achieving the goals. The partnerships showcase the ability of nurses to serve as change agents in creating systems that bridge the delivery of health care and social needs care in the community.

The Illinois Public Health Nurse Academic-Practice Partnership Workgroup invites you to a one hour lunchtime webinar showcasing collaboration and partnership in public health and community settings.

When: Wednesday, August 28, 2019
11:00am – 12:00pm
Where: Webinar – live – and recorded
Registration: http://bit.ly/PHWEBINAR

Due to the generous support of the Robert Wood Johnson Foundation and the Illinois Nurses Foundation, the Public Health Nurse Workgroup is able to offer this webinar at no charge to a limited number nurses. We will explore innovative public and community health nursing academic-practice partnerships.

This activity has been submitted to Ohio Nurses Association for approval to award one contact hour. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Learn from the experts, earn valuable CE credit when it's convenient for you.

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Neonatal Hypoglycemia Protocol Project

By Callie Binosi Asmann
Advisors - Jan Akright and Josey Harris

It is estimated that 15% of all neonates are at risk for neonatal hypoglycemia (Rewat et al., 2016). The previous neonatal hypoglycemia protocol at one hospital in West Central Illinois was to screen neonates that have predisposing risk factors with a capillary heal-lance blood sample and measured with a bedside glucometer. Predisposing risk factors include preterm, post-term, small for gestational age, large for gestational age, infants of diabetic mothers, and infants of mothers who received late preterm corticosteroids. Under the previous protocol the specific target range was a blood glucose level greater than or equal to 40mg/dL. Infants with glucometer readings less than 40mg/dL would receive supplemental infant formula or IV dextrose in severe cases. This practice caused disruption in breastfeeding, possible interference of mother/baby bonding, and increased costs. Fortunately, research within the last 10 years has shown promising results when using oral glucose/dextrose as safe and effective for treating neonatal hypoglycemia and supports exclusive breastfeeding.

The literature review identified multiple reliable studies which indicated that the use of oral/buccal dextrose gel is a safe, inexpensive and noninvasive treatment modality for neonatal hypoglycemia. This treatment can be done with the neonate in the mother's arms and the baby can go directly back to breast afterwards. With decreased separation of the mother and baby and decreased formula supplementation, potentially, exclusive breastfeeding rates could increase.

Rationale for Project

The Centers for Disease Control (CDC) survey, Maternity Practices in Infant Nutrition and Care (mPINC), was conducted at this Illinois hospital. The results of the survey indicated there were areas of maternity practices related to breastfeeding at the organization that were in need of improvement. Treating asymptomatic hypoglycemic neonates with formula interrupts exclusive breastfeeding. While this treatment may not seem of great consequence, the impact of exclusive breastfeeding should not be overlooked. It is a well-documented fact and supported by the Centers for Disease Control (CDC) (2015), the World Health Organization (WHO) (2014), the American Academy of Pediatricians (AAP) (2012), and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) (2015), that exclusive breastfeeding has defined health benefits for mother and babies. In a position statement on breastfeeding, AWHONN (2015), stated that "Women should be encouraged and supported to exclusively breastfeed for the first six months of an infant's life" (p. 83). The AAP (2012) also recommends exclusive breastfeeding, taking a strong stand on the issue in its 2012 policy statement, stating, "Given the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice" (p. 827).

Parents and staff nurses often ask in regards to formula supplementation, "Does one bottle really matter?" Evidence shows that it is important. An article by Marsha Walker, RN, IBCLC (2014) brings evidence that just one bottle can negatively affect an infant's gut flora for up to four weeks. For infants with a predisposition to certain allergies, just one bottle of formula given during the first three days of life, can sensitize a neonate to cow's milk proteins and lead to dairy allergies later in life (Walker, 2014). Additionally, early exposure to cow's milk protein present in formula may increase an infant's risk of developing insulin-dependent diabetes mellitus (Walker, 2014). Glucose, however, is one of the sugars formed when breastmilk is metabolized; therefore it does not impose the risks on the newborn that milk protein may (Walker, 2014).

Purpose of Project

This project was centered around an evidence-based change to implement a new protocol for treating neonatal hypoglycemia. Just as with the previous protocol, the new protocol continued to screen newborns for risk factors for hypoglycemia and uses bedside glucose monitoring for those babies who meet criteria. The difference in the new protocol was how hypoglycemia was treated. Instead of using supplementary formula or IV dextrose for hypoglycemia, the treatment was a weight-based dose of dextrose gel placed in the newborn's buccal mucosa for quick absorption. In addition to reversing hypoglycemia, it was hoped that this change would help keep mothers exclusively breastfeeding their babies and decrease separation.

Plan to Address Issue

The new protocol and algorithm were approved by the pediatric department at the hospital in February 2018. The new protocol was then used to generate a standing order set to be approved by the Medical Staff Organizational Quality Advisory Council (MSOQAC). After approvals were granted, staff education on the new protocol and administration of the oral glucose occurred. Full implementation of the new protocol began on October 16, 2018. This included glucose monitoring for at risk neonates and administration of weight based oral dextrose gel for neonates who met criteria. This protocol was applied to every baby admitted to the newborn nursery at the hospital. In addition, IRB approval for retrospective chart review was approved in October 2018.

Outcomes

This project gathered information on breastfeeding exclusivity before and after implementation of the new hypoglycemia protocol. The data was compared to see how the new treatment allowed for newborns to remain exclusively breastfed and avoid formula supplementation. The project also monitored outcomes for the new intervention to analyze its efficacy. Although not measured, it was anticipated to improve patient satisfaction as mother's breastfeeding goals were respected and mother/baby separation reduced. The projected outcome was to increase breastfeeding exclusivity.

Results

For all babies at the hospital, exclusive breastfeeding rate in January 2018 (nine months pre implementation) was 74%. The exclusive breastfeeding rate in July 2019 (three months pre implementation) was 72%. In January of 2019 (three months post implementation) the exclusive breastfeeding rate was 69%. The data for nine months post implementation, will be collected in June of 2019 and reported.

In July 2018, three months prior to implementation of the new neonatal hypoglycemia protocol, 34 neonates were identified with risk factors for neonatal hypoglycemia. Fourteen of the 34 at risk neonates met criteria to receive treatment for hypoglycemia under the new protocol. Of the 14 identified, all 14 required formula supplementation for treatment of hypoglycemia.

In the third month post protocol implementation, 25 neonates met the criteria to receive oral dextrose gel. Thirteen of the 25, or 52%, who required oral dextrose gel due to glucometer readings below criteria were able to continue exclusive breastfeeding after treatment. This is a 52% increase in exclusive breastfeeding over the pre-implementation outcome where 100% of the hypoglycemic newborns required formula.

Discussion

The overall breastfeeding exclusivity rate of all births at this hospital was not impacted by the implementation of using dextrose gel for the treatment of neonatal hypoglycemia. This may be due to the fact that there were multiple factors that contributed to the mother's choice of how to feed her baby. When comparing pre- and post-implementation data, it was found that of the neonates with risk factors for hypoglycemia requiring treatment, 52% under the new protocol were able to remain exclusively breastfed as opposed to 0% under the old protocol. The newborn nursery will continue to use the new neonatal hypoglycemia protocol and treat neonates that meet criteria with oral dextrose gel. The outcomes will be measured again at nine months post implementation and reported.

NEONATAL HYPOGLYCEMIA PROTOCOL

Symptoms of Hypoglycemia

Jitteriness	Lethargy	Tachypenea
Hypothermia	Poor Feeding	Cyanosis
Hypotonia	Apnea	
Weak/High pitched cry	Seizures/eye rolling	

Risk Factors of Hypoglycemia

Late preterm (34-36 6/7 weeks)	5 Minute APGAR <7
Post-term (>42 weeks)	SGA (small for gestational age)
Infant of a diabetic mother	LGA (large for gestational age)
Infants of mothers who received late preterm corticosteroids	

IF SYMPTOMATIC - BEDSIDE GLUCOMETER

If Aymptomatic with risk factors only:
- Feed 1st within 1 hour of birth:
- Screen bedside glucometer 1 hour after

Bedside glucometer <30 mg/dl
- **STAT NOTIFICATION OF PHYSICIAN**
- Administer oral dextrose gel according to dosing guideline
- Consider IV access for symptomatic infant and infants unable to feed
- May be fed AFTER bolus
- Glucometer 1 hour after bolus
- Consider re-bolus for accuchecks <30
- IV Wean: Once glucometers >45 wean IVF by 2ml/hr or per physician order.

Bedside glucometer 30-44 mg/dl
- Notify physician
- Administer oral dextrose gel according to dosing guideline
- Feed newborn
- Skin to skin unless contraindicated

Repeat bedside glucometer in 1 hour

May give total of 3 doses of dextrose gel, notify physician of persistent hypoglycemia

Bedside glucometer >45 mg/dl
Continue feeds q 2-3 hours
Bedside glucometer before each feed for 24 hrs
Call physician after 3rd glucose check >45 mg/dl

40% Dextrose gel Dosing Guidelines
Dry baby's mouth with gauze, used gloved finger to administer and massage 1/4 dose at a time to each cheek. Repeat until entire dose is given.

Weight of Infant	40% dextrose gel Dose
1.5-2 kg	1 ml (400 mg)
2-3 kg	1.5 ml (600 mg)
3-4 kg	2 ml (800 mg)
4-5 kg	2.5 ml (1000 mg)

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Hektoen Nurses and the Humanities

Please join us on Thursday, July 25, 2019 , at 6 PM for "Pursing the Ephemeral, Painting the Enduring: Alzheimer's Disease and the Artwork of William Untermohlen." William Untermohlen produced a series of seven paintings as his disease progressed. Dr. Noel Kerr and Dr. Wendy Kooken of Illinois Wesleyan University will discuss the intersection of art and illness. Admission is free.

For further information please see Nurses and the Humanities on Facebook or contact Sandra Gaynor, PhD, RN at 773-822-1494.

Illinois Association of Nurse Anesthetists

Advancing Patient Safety & Excellence in Anesthesia

Rosemarie D. Slowikowski, DNP, CRNA
Immediate Past President
Illinois Association of Nurse Anesthetists

The Illinois Association of Nurse Anesthetist (IANA) moves forward in 2019 with its goal to promote the art of Nurse Anesthesia practice. Its mission is to evolve the nurse anesthesia profession "…in Illinois through health policy advocacy, education, and transformational leadership to advance patient safety and access to quality care." Currently, there are over 1,900 Certified Registered Nurse Anesthetists (CRNA) in Illinois. As the predominant providers in rural areas, underserved communities, forward military zone hospitals and in Veteran Affairs Facilities, CRNAs improve access to care.

In 2019, the IANA celebrated its 80th anniversary. Observance of this milestone continued at the Spring conference on May 18 in Champaign, Illinois. During CRNA Week the IANA increased its' social media presence and hosted numerous public relations campaigns. In addition, the IANA website went through a major overhaul to improve member access to information. Grass roots lobby efforts fosters relationships with key stakeholders, other APRN organizations and legislators.

The IANA faced a challenging 2019 legislative session. As one of the primary goals of the IANA, SB 1683 and HB 2813 sought to expand CRNA practice. Advancements were made to remove the physical presence of an anesthesiologist from a requirement in the Nurse Practice Act. Senator Emil Jones progressed the senate bill to a 3rd reading. The deadline has passed to transfer the bill from one chamber to another so the bill will not advance this legislative session, however this is a huge step in reaching greater autonomy. The IANA plans to work toward greater CRNA independence and the ability to practice to the full scope of CRNAs' training and experience. It is imperative that legislators be educated about the value every APRN, including CRNAs, bring to the citizens of Illinois.

At Lobby day on March 19, over 90 CRNAs, SRNAs (Student Registered Nurse Anesthetists) and lobbyists met with state legislators. SRNAs played a pivotal role in leading discussions with legislators. The SRNA representatives from each educational program coordinated meetings with legislators in Washington, D.C. at the Midyear Assembly for the American Association of Nurse Anesthetists (AANA). Each year, CRNAs gather to lobby on Capitol Hill. At this assembly, SRNAs coordinate the IANA meetings with legislators and lead discussions on key issues for nurse anesthetists. Fostering the leadership of SRNAs is crucial to the growth of the profession of CRNAs.

The IANA envisions a future that promotes collaboration and expanded scope of practice for all APRNs in Illinois.

Representative Jan Schakowsky (center) with members of the IANA

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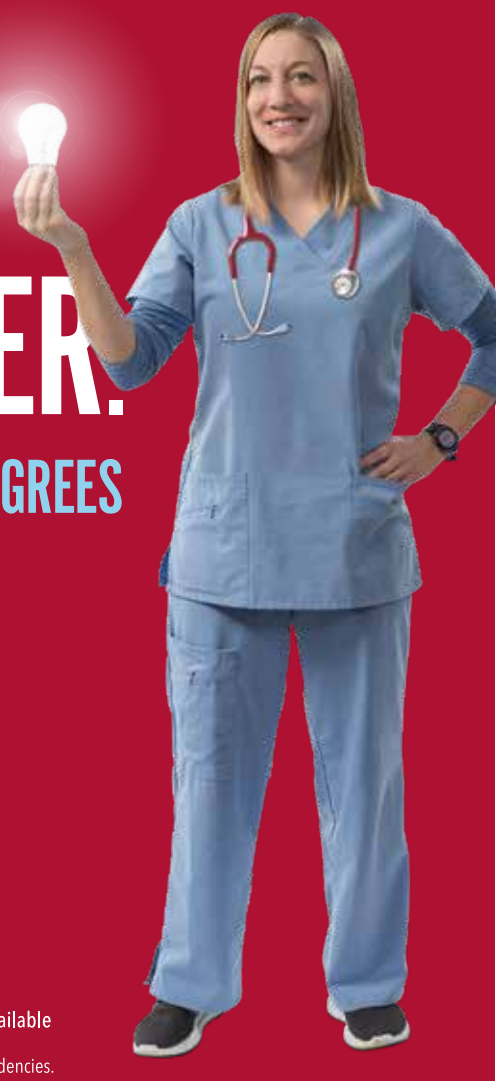

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