Why Breakfast?
Why NOT Breakfast?

Page 11

Nurse Becky Lockhart is First Woman to Become Utah’s Speaker of the House

Provo Rep. Becky Lockhart made history during the 2011 Legislative Session by becoming the first woman to lead the Utah House of Representatives. Not only is she the first woman speaker but she is a registered nurse. In celebrating her position, UNA has asked her to share with us some insight on her life.

How did you become interested in politics?

I have always been interested in State and National issues. I do a lot of reading, mostly history and non-fiction. I got involved in the local Republican Party and found myself more and more interested in serving in the Utah Legislature. Initially, I pictured myself doing this when my young children were grown, but the timing worked differently for our family, and I was first elected when I was just 29 years old.

How has being a nurse prepared you for politics?

Being a nurse has helped make me aware of many of the important health care issues. I can directly relate to many of the effects of legislation and the impacts to the profession. I have a broader view of many medical issues than those who don’t have that background. Also, I bring the viewpoint of a nurse, not a physician. I believe that is vital when considering issues dealing with licensure and expansion of privileges of advanced practice nurses. I can assure my colleagues an APRN is completely and totally competent and acting within her or his experience and training. Doctors shouldn’t be the only voice.

What should nurses do to become involved in the future of health care and the legislation process?

Nurses need to do the basics. You need to know who your elected officials are and who your representatives are. You don’t have to go to dinner with them on a weekly basis, but knowing who they are and calling them or emailing that person about issues creates a relationship. Choose an issue or cause you feel strongly about. Gather all of the information you can about it—all sides. You have to defend your position with legitimate reasons. Gather all of the information you can about it—all sides. You have to defend your position with legitimate reasons. Then, find a group or organization that shares your views and attend the meetings, or make the calls. It’s really very easy.

What do you like about being Speaker of the House?

I enjoy being a part of the decisions that are being made here in Utah. At heart, I am a policy wonk. I love to debate ideas and come up with solutions to problems and challenges. I love being part of the process. I have tried to make the process open and available and interactive. I believe that all ideas are worthy of debate, and so I have tried to make sure that all voices are heard before decisions are made.

What do you like about being Speaker of the House?

I enjoy being able to be a part of the decisions that are being made here in Utah. At heart, I am a policy wonk. I love to debate ideas and come up with solutions to problems and challenges. I love being part of the process. I have tried to make the process open and available and interactive. I believe that all ideas are worthy of debate, and so I have tried to make sure that all voices are heard before decisions are made.

I have never been all that comfortable with the “woman” thing. I am not a “feminist.” I believe a person should be elected for their positions and skills, not because of their sex. I do realize that being the first woman Speaker is of historical significance, though. I hope to be a good role model for girls and women in Utah.

How do you manage all you do and have a family?

I balance my life the way any busy person does. I have...

Rep. Becky Lockhart

Republican, I do not like this legislation, and believe it is unconstitutional, but the way the state interacts with the Federal government and the recipients will consume much of the policy discussion for the next few years.

What do you like about being Speaker of the House?

I enjoy being able to be a part of the decisions that are being made here in Utah. At heart, I am a policy wonk. I love to debate ideas and come up with solutions to problems and challenges. I love being part of the process. I have tried to make the process open and available and interactive. I believe that all ideas are worthy of debate, and so I have tried to make sure that all voices are heard before decisions are made.

I have never been all that comfortable with the “woman” thing. I am not a “feminist.” I believe a person should be elected for their positions and skills, not because of their sex. I do realize that being the first woman Speaker is of historical significance, though. I hope to be a good role model for girls and women in Utah.

How do you manage all you do and have a family?

I balance my life the way any busy person does. I have...

Nurse Becky Lockhart continued on page 2
to prioritize everything. I'm definitely not perfect, and I know my kids have made sacrifices, but I try my best to put family first. I think I'm like most busy people. I don't put family first. I think I'm like most busy people. I don't

Kathleen Kaufman MS, RN

Hello! We have just held our annual conference: “Nurses: Dynamic Links to Care.” A number of excellent speakers gave us ideas for ways that nurses can facilitate quality continuity of care in our communities today. Jane Barton, our keynote speaker, introduced us to the challenges of family caregivers for family members. The final group work for the Utah Nurse Practitioners, Utah Student Nurses Association, Economic & General Welfare

No parts of this publication may be reproduced without permission.

Subscription to Utah Nurse is included with membership to the Utah Nurses Association. Complementary copes are sent to all registered nurses in Utah. Subscriptions available to non-nurse or nurses outside Utah for $25. Circulation 27,000.

All address changes should be directed to DOPL at (801) 530-6628.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@alpub.com. UNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to the next issue or refund of price of advertisement.

Acceptance of advertising does not imply endorsement or approval by the Utah Nurses Association of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. UNA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of UNA or those of the national or local associations.
Dr. Debra Hobbins has an extensive background and education in nursing including receiving in 1974 an associate degree in nursing from BYU, in 1983, she received a Women’s Health Care Nurse Practitioner Certificate, Harbor General Hospital/UCLA School of Medicine, and in 1986, a BSN from California State University Long Beach, a SNP in 1994, and a MSN from California State University Dominguez Hills. In 2010, she completed her DNP from the University of Utah.

Dr. Hobbins has worked in a number of clinical settings—from intensive care and labor and delivery to outpatient women’s health, prenatal, veterans’ and home health care, to ambulatory care for college students and individuals with the diseases of addiction and chronic pain. She has also been on faculty at BYU and the U of U, teaching courses in maternal/newborn, women’s health, physical assessment, nursing fundamentals and clinical rotations. She has held several administrative positions, including Associate Chief Nurse, CEO, Regional Director, manager, and supervisor in various agencies. In addition to her current positions as Bureau Manager for the Utah Division of Occupational and Professional Licensing, she treats chronic pain in private practice; addiction at Tranquility Place; and is Executive Research Scientist at Lifetree Clinical Research, all of which are located in Salt Lake City. Dr. Hobbins has been invited to serve on, and

is currently active in local, state, and national committees dealing with substance abuse, addiction, and addiction treatment.

Dr. Hobbins has been nominated by colleagues and received numerous local, regional, and national awards for excellence in clinical practice, education, service, and mentoring. She was selected as the national Pfizer/ American Academy of Nurse Practitioners Nurse Practitioner of the Year in 1999. She has been listed for decades in various Who’s Who publications and is a member of Sigma Theta Tau. Deb served as national Practice Chair, member of the Board of Directors, Chair of the Nominating Committee, and 2004 President of the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN). She was elected to the ANA Congress on Nursing Practice and Economics. She has also served on several local, national, and international ad hoc committees. She served for several years at the Utah Nurses Association Lobbyist, representing the profession’s interests on Utah’s Capitol Hill and was instrumental in the drafting and passage of important legislation.

My major life accomplishment is being the mother of ten children. Being a mother has taught me more about unconditional love, life, sacrifice, forgiveness, selflessness, more than any experience in life. Professionally, I have been privileged to share in many of life’s most humbling, singular, and meaningful experiences with my patients. I take comfort in knowing, when I leave work every day, that I have made a difference for good in the life of at least one person. I have been able to positively influence, through direct and indirect care, the health and wellbeing of thousands of men, women, and children. Lastly, my professional associations have allowed me to love and learn from my peers. Indeed, like Newton, “If I have seen further it is only by standing on the shoulders of giants.”

Dr. Debra Hobbins named the new Bureau Manager for the Utah Division of Occupational and Professional Licensing

Debra Hobbins

The Official Publication of the Utah Nursing Association

1 Nurse Becky Lockhart is First Woman to Become Utah’s Speaker of the House
2 President’s Message
4 Utah Nurses Association Conference 2011
8 Health Care Reform in Utah
10 Utah Nurse Practitioners, Inc.
12 Eliminating Patient Lifting Injuries
14 In Memorium
14 Utah Midwife in History
15 Membership Application

Attention UNA Members

You can now find us on Facebook. Just search Utah Nurses Association and look for the page with the UNA logo. We will be posting updates for upcoming events and information on conventions in our blog.

Volunteers Needed!

Utah Responds is a statewide web based volunteer registry for health professionals. Register with Utah Responds and select your county’s Medical Reserve Corps unit.

www.utahresponds.org

By registering now, your licenses, qualifications, and credentials will be verified in advance so you will be ready to respond as a credentialed volunteer using your skills and training during a disaster or public health crisis.

www.utahresponds.org

Administered by: In partnership with:
Those who attended this year’s conference were treated to eleven speakers who focused on ways in which nurses participate in the health care system to help meet the needs of critical conditions and the patient. Chronic disease now surpasses communicable disease as America’s number one health care concern. The cost of chronic disease is enormous. Thirty percent of the U.S. population have a chronic disease and the numbers are growing. The financial burden on our healthcare system is overwhelming and the burden on individuals and families is devastating. This year’s conference was designed to meet new challenges presented by the Affordable Care Act.

At this conference, we examined ways in which nurses can make a difference in the healthcare system. Key responsibilities, and education should change significantly. We need to focus on the needs of our patients and families. Eighty percent of healthcare dollars are spent on treating chronic disease. The Institute of Medicine report states that chronic disease management requires a new healthcare workforce. These changes will help nurses be proactive in delivering care to patients and families. The Institute stated that “...the sustainable delivery of high-quality care is changing the role of nurses in the health care system. Nurses currently provide a large share of the world’s health care and are a critical component of the health care workforce. They face unique challenges in terms of their education, preparation, roles, and responsibilities, and a need exists to transform the education and preparation of nurses to meet the needs of the twenty-first century.”

The conference was co-hosted by Utah Nurses Association and the University of Utah Nursing Center for Excellence in Practice. There was good attendance and the program was well attended. The topics included: prevention, education, and case management. The conference was especially designed for nurses who are on the front lines of health care delivery.

The keynote presentation on “Vital Connections in Healthcare—Nurses” was given by Jane W. Barton, MTS, MASM. Barton stated the stages of illness as diagnosis, chronicity, and terminal stage. Each stage poses different challenges for the patient, family, and nurse. The phase of diagnosis is one in which all family members respond to the crisis facing the patient. Anxiety and energy are at an all-time high during this stage. During the chronic stage, the family deals with a juggling act in providing care, possibly for a very long time. The primary caregiver tends to become very tired, if not exhausted. In the terminal stage, the family deals with a juggling act in providing care, possibly for a very long time. The primary caregiver tends to become very tired, if not exhausted. In the terminal stage the caregiver, family, and nurse all struggle with the mortality of a loved one and often of ourselves as well. Barton pointed out that families need to set up schedules and ways to give the primary caregiver a rest. Many families will benefit from both support and suggestions from the nurses who care for the patient in a variety of settings. Barton also suggested that social networking sites may also help the family and friends form a care team and set up schedules that meet most needs. One such site is www.livestrong.com. As a nurse, you may want to go to this website, set up a “test team” and try it out before recommending it to your patients.

Penny Jensen, DNP, FNP-C, FAANP, President of the American Academy of Nurse Practitioners, discussed “Health Care Policy and Reform: The Affordable Care Act.” In explaining the need for the Affordable Care Act she pointed out that United States ranks 43rd lowest in infant mortality in the world and 42nd for life expectancy. Yet we spend the most in healthcare dollars. In fact 95 cents of every dollar is spent on treat disease after it occurs. Chronic disease now surpasses communicable disease as a cause of death worldwide. Chronic diseases consume 75% of healthcare expenditures in the US. Many of these conditions and associated deaths can be prevented because they are related to diabetes, obesity, heart disease, lung disease, high blood pressure and cancer. The economic impact is large in that 46% of bankruptcies are associated with medical issues. Cardiovascular disease is #1 and #2 in mortality. Diabetes is #8 and #9. If lifestyle changes were implemented this would change. The Affordable Care Act was designed to improve quality of care and control costs. It was designed to control costs and focus on quality care. The Affordable Care Act was designed to improve quality of care and control costs. It was designed to control costs and focus on quality care. When patients experience in delay of care when they find out the diagnosis the problems are associated with the home care agency and the discharging hospital. The particular ‘zebras’ were Fentanyl Chest Wall Rigidity Syndrome, Neurogenic Pulmonary Edema, and Neurogenic Pulmonary Edema. Blaine Winters, DNP, ACNP, presentation was about “Diagnosing ‘Zebras.’” The particular ‘zebras’ were Fentanyl Chest Wall Rigidity Syndrome, Neurogenic Pulmonary Edema, and Neurogenic Pulmonary Edema. Blaine Winters used a case study teaching approach to these unusual outpatient problems.

The first case study was a young woman who chose to undergo intravenous fentanyl conscious sedation for tooth extraction. The second case study illustrated the presentation of neurogenic pulmonary edema which can be associated with neurologic events in the outpatient or inpatient setting. Both case studies were presented by the third case, a 34-year-old male participating in rescue drills with the fire department. This problem can also occur in climbers, people using industrial harnesses, and military recruits standing at attention for long periods of time.

Carolyn Morrison, BSN, RN, COS-C, a Nurse Manager for Applegate Homecare and Hospice, “Pragmatics of Home Care” which was about discharge planning for patients and families. Most patients will be discharged to home care and factors to consider in making referrals. Ms. Morrison explained that not every agency can obtain reimbursement for a diagnosis. She explained the problems that patients experience in delay of care when they find out after discharge that their insurance company will not pay for these services. Many times the patient must be transferred to a different agency. We were reminded of the importance of maintaining good communication between the home care agency and the discharging hospital.

Marilyn K. Johnson, RN from the National Alliance of Drug Endangered Children (NADEC) Training Program. The mission of the National Drug Endangered Children Network is to break the cycle of abuse and neglect in a way that works. These brain changes can be long lasting. Everyone is a mandatory reporter. Utah Code 62A-4a-403 states “If anyone has reason to believe that a child has been subjected to neglect, maltreatment, sexual exploitation, sexual abuse, or physical abuse, or neglect, he shall immediately notify the nearest peace officer, law enforcement agency, or office of the division.” Volunteers are needed to help with this important work. Anyone interested in volunteering can do so through the website, http://www.nationaldec.org.

Yad Calhoun M.A., M.S., RYT, from GreenTree Yoga conducted an active session “Simple Yoga Tools for Stress Management both for Self-Care and for Patients and their Families.” Those who attended were introduced to yoga as a healing tool both for self-care and to help patients and their families, with the intention of teaching simple stress management tools and of addressing compassion fatigue and vicarious trauma. Ms. Calhoun explained that there are many kinds of yoga and individuals must experiment and find the type that is right for them and their situation. “If it doesn’t feel good, don’t do it!” One of the reasons it works is due to the way it works. These brain changes can be long lasting. Everyone is a mandatory reporter. Utah Code 62A-4a-403 states “If anyone has reason to believe that a child has been subjected to neglect, maltreatment, sexual exploitation, sexual abuse, or neglect, he shall immediately notify the nearest peace officer, law enforcement agency, or office of the division.” Volunteers are needed to help with this important work. Anyone interested in volunteering can do so through the website, http://www.nationaldec.org.

Nurses: Dynamic Links to Care

- Medicaid will provide health care services after Oct 1, 2011
- By Oct 1, 2012 standardized billing and value-based purchasing programs will be included in Medicare
- By January 2013, primary care physicians will receive 100% of Medicare payment rates.
- By 2018 all insurance plans must cover preventive care without copayments.

The Institute of Medicine report The Future of Nursing: Leading Change and Advancing Health is a blueprint for the future of nursing. It explores how nurses’ roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America’s increasingly complex health system. Key messages from the report include:

1. Nurses should practice to the full extent of their education and training.
2. Nurses must achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses must work as full partners with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making should replace current disjointed approaches.

Recommendations that would affect advanced nursing practice are:

- Expansion of Medicare to include coverage of APRNs to the same level as physicians.
- Authorization of APRNs to admit to long term care, including long term hospital and hospice services.
- Equity in Medicaid reimbursement.
- Review of state practice acts and regulations regarding APRN practice regulation.

Dr. Jensen concluded with a discussion of terminology to use in discussing nursing’s role in the health care debate.

Gina Coccimiglio, MN, CHPN, CMC, WCC, Chief Clinical Officer and Co-Owner of CareSource Home Health & Hospice, presented “Patient Choice: Hospice or Palliative Care.” She pointed out that Coccimiglio explained how to know when to discuss about hospice, hospice and hospice is appropriate. She discussed the small number of agencies in Utah that provide these services. Information was provided on the differences between palliative care and hospice. Palliative care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care can be accessed anytime during the course of a serious illness and can be provided along with curative treatment. Hospice care is intended to be offered at the end of life. It is usually implemented when the patient’s life expectancy is less than 6 months. The emphasis is on caring, not curing. In most cases hospice care is provided to a patient in his or her own home. However, it also can be provided in freestanding hospice facilities, hospitals, hospice and other long-term care facilities. Clinically the two are very similar in the focus on comfort care. Financially, there are some differences in that payment for hospice care is limited to the day. Palliative care in hospice is focused on end of life counseling and bereavement.

The Utah Nurse November, December 2011, January 2012

UNA Conference 2011 continued on page 5
Sue Chase-Cantarini, RN, MS and Sherri Evershed, RN, MSPh, DNSc provided a very informative session on “Health Literacy.” They defined health literacy as the “ability to obtain, process, and understand basic health information needed to make appropriate health decisions.” Examples of the difficulty patients have in interpreting information given by healthcare professionals were illustrative and poignant. Health literacy is especially important as healthcare is assumed by more and more non-professionals. In fact literacy skills are now “a stronger predictor of health status than age, income, education, employment or racial/ethnic group.” The types and levels of literacy as well as risk groups were described. Some statistics were shared: 28% of all students in Utah do not graduate with a high school diploma, and 15% of adults aged 65 and higher have inadequate literacy skills. It is important to understand the difficulty of assessing health literacy and to recognize that “it usually cannot be detected in a simple conversation.” Clues can be found in patient comments “I’ll bring this home so I can discuss it with my family” and behaviors such as missed appointments or apparent non-compliance. Attendees were encouraged to use the Teach Back method and ask patients how they would explain to a friend and show how they would take their medicines. The session concluded with some very useful tips on constructing effective patient education handouts and websites. A list of top ten consumer health websites was also provided.

“When It Hurts to Care: Compassion Fatigue” was a breakout session given by the keynote speaker, Jane Barton, MTS, MASM. She explained that compassion fatigue occurs as a result of over identification with the suffering of others. As professional or personal caregivers, we are at risk because we witness the suffering of others—physical, emotional, and spiritual. Signs and symptoms of compassion fatigue are feeling: pushed beyond ones limits, barely hanging on, beyond physical exhaustion, irritated, anxious, angry, isolated, despairing, and/or everything in life is challenging. Behaviors that others may see include: frequent medical problems, blaming others, doing everything to excess, self-medication with alcohol or other substances, disruption in sleep habits. The important thing is for individuals to know and recognize how they manifest stress. We should give others permission to notify us of our manifestations of stress and then we should take steps to modify our situation. An analogy of a rope was given. Ropes are responsibilities we hold on to either because we assign ourselves or believe others have assigned us. Periodically we should examine our ropes, clarify our roles and review our motivations for holding them. We may find that some responsibilities are actually not ours. This brought up the issue of boundaries. We must always be aware of where we end and the other person begins. We can companion others in life, but we cannot assume the responsibility for another’s life. Self-awareness and self-care will help us remain enlightened and empowered.

The day concluded with a panel “Helping Families to Care from a Distance.” The panelists were Jane Barton, Kathleen Kaufman, Donna Eliason, and Sandra Haak. The session used a case-based approach to give the conference participants an opportunity to apply what they learned in the other sessions during the day. Ms. Barton gave a quick overview of the issues involved in helping families at distance to participate in a loved one’s care. Ms. Kaufman and Eliason then presented personal experiences as family members. Ms. Kaufman described a brother’s long illness and eventual death from a brain tumor. Ms. Eliason discussed her mother-in-law’s present illness with heart failure. The panelists were Jane Barton, MTS, MASM. She explained that compassion fatigue occurs as a result of over identification with the suffering of others. As professional or personal caregivers, we are at risk because we witness the suffering of others—physical, emotional, and spiritual. Signs and symptoms of compassion fatigue are feeling: pushed beyond ones limits, barely hanging on, beyond physical exhaustion, irritated, anxious, angry, isolated, despairing, and/or everything in life is challenging. Behaviors that others may see include: frequent medical problems, blaming others, doing everything to excess, self-medication with alcohol or other substances, disruption in sleep habits. The important thing is for individuals to know and recognize how they manifest stress. We should give others permission to notify us of our manifestations of stress and then we should take steps to modify our situation. An analogy of a rope was given. Ropes are responsibilities we hold on to either because we assign ourselves or believe others have assigned us. Periodically we should examine our ropes, clarify our roles and review our motivations for holding them. We may find that some responsibilities are actually not ours. This brought up the issue of boundaries. We must always be aware of where we end and the other person begins. We can companion others in life, but we cannot assume the responsibility for another’s life. Self-awareness and self-care will help us remain enlightened and empowered.
House of Delegates Passes 2011 Bylaws Revisions

The House of Delegates voted to pass the significantly revised bylaws for the Utah Nurses Association. The major changes in the bylaws will now allow electronic meetings and electronic votes if needed by the organization. This was viewed as essential based on the great difficulty in getting a full quorum of the House of Delegates together in one place in Utah. While we plan to continue to hold House of Delegates meetings in person in the future, we now have an alternative if we need to get business done in a timely way.

In revising the bylaws, the mission statement was made more succinct: “The mission of the UNA is to advocate, educate, and be a voice for all nurses in Utah both individually and as a whole by promoting and facilitating the roles and functions of nurses in all areas of employment and in all aspects of professional practice.”

The new revision deletes both the concept of districts (which is the old structure of our association and has not functioned well for years) and also the economic and general welfare article since this is no longer consistent with the structure of the American Nurses Association. Other changes were primarily name changes to agree with the structure of the American Nurses Association. In revising the bylaws, the mission statement was made more succinct: “The mission of the UNA is to advocate, educate, and be a voice for all nurses in Utah both individually and as a whole by promoting and facilitating the roles and functions of nurses in all areas of employment and in all aspects of professional practice.”

The new revision deletes both the concept of districts (which is the old structure of our association and has not functioned well for years) and also the economic and general welfare article since this is no longer consistent with the structure of the American Nurses Association. Other changes were primarily name changes to agree with the structure of the American Nurses Association.

This year the Board of Directors met monthly. The major work of the Board of Directors has been to update the association’s bylaws which have been reviewed and approved by the American Nurses Association. Sandra Haak PhD, RN has been hired as the new Director of Continuing Education. She is preparing for UNA’s accreditation as an accredited approver unit. She has also served as the chair of the Conference Committee. The theme of the conference this year has been “Nurses: Dynamics Links to Care.”

The office of the Utah Nurses Association has been moved from Room 135 to Room 330B in the Eagle Plaza Building as a cost-saving measure. This has saved the association $350 per month. The new quarters are cozy yet functional. Visitors are welcome. Lisa Trim, office manager is at the office Monday through Thursday from 0900 to 1500.

The Board of Directors has also met with representatives of our affiliate organizations: the School Nurses Association, the Utah Nurse Practitioners, AORN, and the Utah Student Nurses Association. We plan to interact regularly to our mutual benefits. We currently do publish information for these organizations in our quarterly newsletter.

The membership was surveyed early in the year regarding desired new and useful areas of information for the Utah Nurse. The most favored topics were “healthy eating active living” and health literacy. We are including articles on these topics as well as regular articles on healthcare reform in the newsletter for the benefit of all registered nurses in Utah. A new focus on nurses as volunteers is also included as material is available. We welcome submissions on these topics. Deadlines for submission are printed in each issue of the newsletter.

Current membership stands at 420 members representing the 26,000 nurses of Utah. The work of the association is carried out by fewer than 20 active members. We welcome, we NEED, more participation. Our lobbyist, Michelle Swift has represented us ably in the legislative session this year. Please contact UNA@eismission.com with any ideas of how you might help with the work of UNA.

The president has represented the Utah Nurses Association in a variety of venues this year. Attending the ANA Constituent Assembly meeting in March enabled networking with other state associations and with ANA leaders. The president has also attended and occasionally testified at Medicaid hearings and the Regional Action Coalition on healthcare reform; and served as the keynote speaker at the annual Utah Student Nurse Association conference.

The Church of Jesus Christ of Latter-Day Saints at a luncheon honored the Utah Nurses Association as a representative of the outstanding nurses of Utah earlier this year. Several officers and active members attended the luncheon.

Respectfully submitted,
Kathleen Kaufman, President

President’s Annual Report to the House of Delegates and Members

Kathleen Kaufman MS, RN

Utah Nurses Association Annual Conference 2012

will be held September 28, 2012 from 8:00 AM to 5:00 PM at the Karen G. Miller Conference Center on the Salt Lake Community College Miller campus 9750 South 300 West Sandy, Utah 84070

Topics will include:

• Health Care Policy and Legislation
• Care for Caregivers
• Current Clinical Topics
• Community Resources

Make your nursing research easy...nursingALD.com Access to over 10 years of nursing publications at your fingertips.

Believe in touching lives.
Home healthcare allows you to see one patient at a time like you imagined when you started your career. When you become a part of home healthcare, you become a part of your patients’ lives.

Registered Nurses
Work one-on-one with patients
Treat a wide range of diagnoses
Receive specialized training

Call us today at 1.866.GENTIVA
Visit us at gentiva.com/careers
Email bill.barber@gentiva.com

PROFESSOR
ASSISTANT
NURSING

Coordinate & teach in both undergraduate and graduate level courses. Required to plan, implement and evaluate existing curriculum.

• MSN: graduated from an NLNAC or CNNE
• One year experience
• Current unencumbered Utah RN license

View details and apply online
http://jobs.weber.edu

nursingALD.com

• Current Clinical Topics
• Care for Caregivers
• Current Clinical Topics
• Community Resources
Volunteering in the State of Utah

A number of people at the UNA conference asked about opportunities to volunteer. The Utah Commission on Volunteers has a website http://volunteers.utah.gov/ which provides links to volunteer centers in all Utah counties. It also provides links to and information about programs and opportunities throughout the state.

Volunteering in Salt Lake County

If you are interested in volunteering for groups in Salt Lake County, the website www.alittletime.org will connect you with Salt Lake County Volunteer Services. The volunteer opportunities for Salt Lake County are listed as well as links to community partners. There is a special program for retired seniors and Vicki Jo Hansen with RSVP (Retired Senior Volunteer Program) is great to work with folks to make sure they have a good fit for giving their time. The Health Access Project is especially looking for volunteers interested in giving time in the healthcare arena.
What is Happening with Healthcare Reform in Utah?

Background

The Utah Regional Action Coalition for Health brings together many of the state’s strongest leaders in improving health care quality, access and affordability. The Utah Organization of Nurse Leaders (UONL) and HealthInsight formed a new partnership to lead the Coalition. The group’s leadership circle brings together a diverse group of state health care leaders, including Intermountain HealthCare, the Department of Professional Licensing of the state Board of Nursing, the Utah Department of Health, the University of Utah Health Sciences, the Utah Hospitals and Health Systems Association, a state legislator who serves on the Utah House Health and Human Services Committee, the Utah Association for Community Health, and AARP Utah.

The Coalition has already begun work on a variety of initiatives related to the recommendations of the IOM report. They have successfully encouraged the director of the Utah Medicaid Office to pilot test a model for expanded reimbursement for APRN’s practicing in rural areas of the state, an initiative which the Coalition plans to learn from and build upon to expand access to care. The Coalition also plans to create more seamless educational pathways from entry level to doctoral education and increase the percentages of both baccalaureate and doctoral prepared nurses.

To begin this process, they have appointed a co-coordinating council and an advisory board. Two large work groups have been formed. The Education & Practice Work Group has prioritized IOM Recommendations 3 & 4. An articulation taskforce consisting of deans and directors of AD and BS programs has been asked to review current articulation agreements. BS program capacity and explore models of progression. Existing nurse residency programs will be evaluated and new programs developed to support increased nurse and NP effectiveness and workforce retention. The Leadership and Collaboration Work Group will explore health care reform initiatives and projects in the state as they address IOM Recommendation 2 & 7. Opportunities to develop and appoint nurse leaders within accountable care organizational structures as well as strategies to promote interprofessional collaboration and development of new models of team-based, community-based health care will be designed. In addition each Work Group will be charged with identifying the critical data elements and information needs in their area of focus.

Priorities

<table>
<thead>
<tr>
<th>Education and Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah Org of Nurse Leaders</td>
</tr>
<tr>
<td>UONL, Academic Leadership Committee</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
</tr>
<tr>
<td>Department of Health</td>
</tr>
<tr>
<td>DOPL – State Board of Nursing</td>
</tr>
<tr>
<td>Medical Education Council</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership and Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthInsight</td>
</tr>
<tr>
<td>University of Utah Health Sciences</td>
</tr>
<tr>
<td>AARP Utah State Office</td>
</tr>
<tr>
<td>Utah Medicaid &amp; Health Financing Division</td>
</tr>
<tr>
<td>Utah Association for Community Health</td>
</tr>
<tr>
<td>Medical Education Council</td>
</tr>
</tbody>
</table>

As you can see, the Utah Nurses Association is NOT listed as a partner in the Utah Regional Action Coalition for Health. This may be due to the small number of actual active members to do the work required by such a partnership. Kathleen Kaufman has been representing the association at meetings thus far and plans to continue to do so with nurses’ input. The UNA board is currently discussing how best to in the process of disseminating information from the work of the coalition and soliciting input from the thousands of nurses in Utah. We have already initiated a health reform column in the Utah Nurse which has presented information from the Utah Health Policy Project on health reform and Medicaid. We will continue this column and possibly initiate a tool on the association’s website to aid in the collection of information. Please direct any input you may have to the UNA at una@xmission.com.

The co-leads of the coalition include three nurses and the executive director of HealthInsight, Maureen Keefe, Dean at the University of Utah College of Nursing represents the UONL Board of Directors. Gail McGuill is the Senior Nurse Consultant for HealthLinx Consulting. Kevin Martin is the Director of Patient Care Services and CNO of Shriner’s Hospital in Salt Lake City. Doug Haschroot is the Executive Director of HealthInsight, a policy and information organization.

If you wish to share your opinion of health care reform with a wider audience of nurses, please feel free to send in a “Letter to the Editor.” We will print your opinion in the next quarterly Utah Nurse. If you want to share your input directly with the Regional Action Coalition, then we can also facilitate that or you can contact Kevin Martin or Michelle Carlson as indicated in the accompanying article in this issue on the work of the coalition. Periodically we anticipate asking for opinions on specific proposed items or actions. Please respond and have an input on healthcare reform in this state!
Solutions to Advance Healthcare in Your State

- Registered Nurses (RNs) should practice to the full extent of their education and training; scope of practice barriers should be removed.
- Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
- Better data collection and an improved information infrastructure are required for effective workforce planning and policy making.
- Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

The October 2010 Institute of Medicine report – The Future of Nursing: Leading Change, Advancing Health—led by a committee of nationally renowned health care experts from nursing, medicine, and other disciplines resulted in a number of conclusions and recommendations which are highlighted here.

Background

Nurses represent the largest segment of the health professions at 3.1 million in the U.S. Surveys tell us that nursing is the most trusted profession in America. They also tell us that Americans rank nurses above eight different health care providers in the United States for the quality of care they provide. Gallup survey of 1,500 opinion leaders* said nurses should have more:

- Influence in reducing medical errors, increasing quality of care, promoting wellness
- Input and impact in planning, policy development and management

Workforce Planning Solutions

Better data collection and an improved information infrastructure are required for effective workforce planning and policy making.

Support funding for research and collection of standardized health care workforce statistics.

Background

Current research and workforce data collection is fragmented and is evidenced in failure to effectively plan for addressing the education needs and fluctuations in the health care labor force.

Planning for fundamental, wide-ranging changes in the education and deployment of the nursing workforce will demand comprehensive data on the entire health care workforce—the numbers and types of health professionals currently available and what will be needed in coming years.

With an improved infrastructure for collecting and analyzing data, systematic assessment and projection of workforce requirements by role, skill mix, region and demographics will inform future decisions about nursing education and practice.

Advanced Practice Nurses

Advanced practice registered nurses (APRNs) have made significant contributions in meeting the nation’s health care needs by improving access to healthcare services. APRNs include nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialist. Research conducted over decades demonstrates that APRNs provide high quality care.

There is no uniform approach to the regulation of APRNs across the states creating barriers for APRNs who may wish to move from state-to-state. Regulations in many states limit APRNs from practicing autonomously and decrease patient access to APRN care. The APRN Consensus Model was developed to address these problems. It includes a model to standardize the regulation of APRNs through licensure, accreditation, certification and education.

While APRNs in some states are able to practice and prescribe autonomously, the majority of states limit the ability of APRNs to practice to the full extent of their education and training. These restrictions include requirements for collaborative agreements with or supervision by a physician, prescribing limitations, and lack of third-party reimbursement.

The 2010 Institute of Medicine report, The Future of Nursing: Leading Change, Advancing Health, recommended removing scope of practice barriers to allow APRNs to practice to the full extent of their education and training. The recommendations specifically called for reforming scope of practice regulations and requiring third-party payers that participate to provide direct reimbursement to APRNs who are practicing within their scope of practice under state law.

Education Solutions

Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.

Specifically, increase the percentage of BSNs to 80 percent by 2020 and double the number of nurses with a doctorate degree by 2020.

Support efforts that result in a smooth transition between educational programs as well as recognition of non-traditional programs.

Education Solutions

Support funding for scholarships and loan forgiveness programs.

Support legislation that amends the Nurse Practice Act, requiring RNs to attain a baccalaureate degree within ten years of licensure, grand- parenting currently licensed nurses and matriculated nursing students.

Many more approaches exist that are non legislative / regulatory.

Background

There are multiple educational pathways that can lead to an entry-level nursing license, which is unique among the health professions.

The licensed practical nurse (LPN), licensed vocational nurse (LVN), diploma, and associate’s (ADN) degree programs should smoothly transition students toward the bachelor’s (BSN), master’s, PhD and doctor of nursing practice (DNP) degrees.

Those higher degrees are key to supplying the advanced-practice nurses who will help overcome primary care shortages. Graduate degrees also are essential to increasing faculty ranks, thereby adding the necessary capacity to expand enrollment at all levels of nursing education.

Demands on nurses are growing as our health care delivery system grows more complex. This will require nurses to obtain an advanced education that expands their knowledge base and competencies.

Research supports this. Studies show that lower mortality rates, fewer medication errors, and positive outcomes are all linked to nurses prepared at the baccalaureate and graduate degree levels.

There’s been an increase in the number of nurses pursuing advanced education, but the numbers are still too low. As a result, efforts to produce adequate nursing faculty or advanced practice RNs to meet future demands will be seriously impeded – in fact, they already are.

A recent study released by the Jonas Center for Nursing Excellence found that because of the shortage of nursing faculty, more than 52,000 qualified applicants were denied entry to nursing programs in 2010.

And the impact of this shortage on health care is profound. According to the same study, each nurse educator position left vacant could impact health care delivery for 3.6 million patients.

Over the next decade, more than half of current nursing faculty is expected to retire, along with as many as 500,000 experienced nurses from the clinical workforce.

For connection to state nurses associations, go to nursingworld.org/FunctionalMenuCategories/AboutANA/WhoWeAre/CMA.aspx
The goals of UNP for 2011-2012 are the following:

- Continued support of our national organization through group membership.
- Keep members updated regarding important legislation that may impact our practice.
- Work with our local affiliate groups to promote unity in advance practice issues.
- Continue to promote NPs in the community through education and community service.

UNP has four areas of emphasis: communication, education, legislation, and membership. In issues of this newsletter, there will be discussion about UNP’s activities in each of these areas. This piece will discuss UNP’s activities in the area of legislation.

This year UNP retained the services of Chris Bleak, to represent and lobby for 2011 legislation that affects independent nursing practice, and other interested persons. Mr. Bleak will continue as lobbyist for the organization during the 2012 Utah legislative session. During, 2011, the organization’s legislative committee, lead by Lee Moss, was able to promote House Bill 66 which amended the death certificate bill, now allowing nurse practitioners to legally sign death certificates. House Bill 192, promoted by UNP and it’s legislative team, modified Title 58, Occupations and Professions, regarding the Controlled Substances Advisory Committee Act. This bill added two members to the Controlled Substances Advisory Committee: one nurse practitioner; and one representative of the public.

Wendy Rusin, 2011-2012 President of Utah Nurse Practitioners, Inc., commented, “I cannot say enough about legislation during a current legislative session. Frequent trips to the capitol building are necessary to speak on behalf of the UNP, as we form a position on bills that may impact our practice. 2012 is looking to be another big year for the Advance Practice RNs in the state of Utah as we work with Legislation to improve our access to care goals. We have formed the state affiliate group, named Utah ANP alliance, which includes executive board members from UNP, NAPNAP, CMN, CRNA.”

On 10 February, UNP will sponsor “Advanced Practice Day on the Hill.” We encourage all nurse practitioners, students and nurses concerned about issues relative to independent nursing practice, and other interested persons to come to the legislature on that day to assist in helping Utah legislators understand the importance of our practice, legislative issues concerning that practice and how they can assist Utah nurses in improving patient care throughout the state of Utah. For more details concerning this activity, please refer to the UNP website, http://www.utahnp.org.

UNP is a strong and influential organization, which strives to keep our professionals up to date with current health care issues. UNP could not be successful without the efforts of many individuals including the board members, officers, committee members, volunteers and annual members; full and student. If you have not done so already, please join and renew your Utah Nurse Practitioner’s (UNP) membership for the 2011 calendar year. Participation in UNP is an effective way to promote the NP profession and network with other advance practice nurses who work in a diversity of settings and practices. You may join by visiting our web page @ http://www.utahnp.org.

Please contact myself or Wendy Rusin (patricia.rushton@byu.edu, wendy.rusin@utah.edu) with any suggestions you may have about Utah’s nurse practitioner group and their activities. UNP’s sustained strength is through our members support and involvement. We anticipate another year of increased activity and growth for the UNP organization. If you are interested in becoming an officer or working on a committee, please contact us.

Celebrate Nurses at This International Event—Rose Parade 2013

Submitted by Donna J. Eliason MS, RN, CNOR

The website is www.flowers4thefloat.org

We need your help in making this magical event come true!

Imagine nurses being center stage getting all the recognition for the wonderful work they do in caring for their patients around the world! Is it possible? Can it be true?

Yes, it is true. On January 1, 2013, at the world-famous Rose Parade, a parade float designed and decorated with living care and appreciation for every nurse will travel down the parade route in Pasadena, California. This unique and once-in-a-lifetime opportunity is being offered to the nursing community and friends of nurses because of one nurse. Her name is Sally Bixby, RN, MS, CNOR and she will be President of the Tournament of Roses.

There is much to celebrate when you think about Nurses. Nurses touch the lives of everyone—at birth or death and in between—all of us benefit from the care nurses provide. This event provides

- An opportunity for nurses to get noticed about our profession and work with other nurses to create this event
- A meaningful way for a nurse to recognize another nurse
- A fun way for families of nurses to participate in the event
- A celebrationary way to create history by placing nurses in the spotlight where they will be recognized and thanked on an international stage
- Scholarships to nurses with funds collected and not used to build and decorate the float
- A message to those looking for a meaningful career that being a nurse makes a difference in the world.

This event needs your help. Become part of this historic event. Participate by Donating, Decorating & Celebrating. Tell a friend, ask them to donate and ask them to tell a friend too. Keep the information chain going! Visit the website to participate! www.flowers4thefloat.org
Why Breakfast? Why NOT Breakfast?

Most of us heard our mothers (or fathers, or grandmothers) say “Eat your breakfast! Get a good start on your day!” Many of us tell our children the same thing. We have heard it, we say it, yet many of us do not actually eat breakfast. What can we learn that might change this in our lives?

First of all, why is breakfast important? Most of us will not have eaten for 8 to 10 hours before we wake up each morning. This “fast” has let our glucose, and protein levels fall so we are not fully energized for the day to come. Physical and mental efforts all require adequate blood sugar supplies. Protein is more slowly digested than carbohydrates and helps keep our blood sugar levels uniform through the hours after a meal. When we skip breakfast, we are letting ourselves in for a sluggish start to our day. Not only that, but Weight Watchers notes that skipping breakfast tends to make us hungerier later in the day when we may seriously overeat and add to a growing weight problem for many of us.

The United States Department of Agriculture (USDA) has presented the benefits of breakfast for our children as follows:

- Breakfast improves school performance in math and reading, and decrease disciplinary problems and tardiness
- Breakfast supplements essential nutrients such as calcium, iron, B vitamins and Vitamin D, which are often not made up later in the day if missed at breakfast
- Breakfast eaters are less likely to be overweight and frequent cereal eaters tend to weigh less than those who consume cereal less often

Now, many of us already “get” this important message despite some lack of follow-through in actually eating breakfast. What can we do to improve this and spark our days and those of our families?

Perhaps there is “too little time” in the morning to eat? Try planning breakfast as you clean up dinner and set the table with glasses and cereal bowls. Put together part of breakfast ahead of time. This can be as simple as putting cereal or nuts or dried fruit in plastic bags. More elaborate breakfasts call for waffle or muffin batter to be partly assembled during the evening. The American Dietetic Association recommends that each breakfast plan begin with protein, add fiber and then add fresh fruits or vegetables). Keeping breakfast simple on busy days, even as simple as juice and a bowl of cereal is sufficient. If you, or your kids, tend to run from the bathroom out of the door, then pack breakfast to go and eat on the way to work or school. Develop a routine, develop this one good habit.

Plan for breakfast when you shop so that you purchase what is most appealing for your family. Not every person is a cereal eater but whole grain bread, rolls or tortillas with a protein filling makes an excellent start to the day. What protein filling works for you? Maureen Callahan on the Real Simple website has weighed in with suggestions for quick and simple breakfasts with adequate nutrients:

- **Fruit and Cheese**
  A balanced, easy-to-assemble make-ahead morning meal: Grab an apple, wrap 1 to 2 ounces of Cheddar in plastic, and toss ¼ cup of fiber- and protein-rich walnuts into a re-sealable plastic bag.

- **Energy Bars**
  To substitute for a meal, an energy bar should have at least 3 to 5 grams of fiber and 10 grams of protein. Odwalla, Kashii GoLean, and TruSoy are all good options. Because cereal bars rarely have more than 2 grams of protein, kids might be better off adding a stick of Go-Gurt! and a sleeve of peanuts.

- **Cereal “Sundaes”**
  A bowl of fiber-rich bran flakes (about ½ cups) with 8 ounces of low-fat milk is nearly the perfect breakfast. Make it portable by replacing the milk with lemon or vanilla yogurt and mixing it in a to-go container. Increase the fiber and vitamins by adding ¼ cup of nuts or fresh or dried fruit, such as chopped pecans or blueberries.

- **Huevos Rancheros**
  One of the most portable proteins is a hard-cooked egg, but it has no fiber or carbohydrates. So slice it, then roll it in an 8-inch whole-wheat tortilla with a piece of Canadian bacon or lean ham and, if you like, a ½-ounce slice of cheese. Add a tablespoon of salsa or a slice of avocado and a smidgen of vitamin C.

In place of the purchased energy bar, you might consider trying Zonya Foco’s recipe for breakfast cookies. Each pair of cookies does contain 6 grams of protein and 5 grams of fiber. Pair this up with a carton of milk and it makes a meal. Another night-before preparation might be the berry smoothie that my hairdresser, Memory, makes. She mixes a few chunks of frozen banana with some mixed frozen berries, adds cranberry juice, carrot juice, and some frozen chopped spinach and refrigerates this overnight. In the morning she adds some yogurt and blends all together. This largely takes the preparation out of her busy morning. Her friend Sabina prefers a more savory breakfast and lightly scrambles an egg before laying a tortilla on top of the egg so the egg cooks to the tortilla. Then she flips over the combo and lets the tortilla cook a bit while she adds some canned black beans and a good serving of salsa to make a tasty, quick breakfast. There are LOTS of breakfast possibilities for all tastes! Find one YOU can live with!

---

**Breakfast = School Success, © 2008 General Mills, Inc.
***American Dietetic Association, http://www.eatright.org/Public/content.aspx?id=6747

---

Breakfast in a Cookie

This is a brilliant way to get your bowl of oatmeal, milk and fruit all in a convenient, not to mention delicious cookie!

This recipe makes a lot so you can freeze plenty for weeks of quick breakfasts, desserts and snacks.

Position oven racks to accommodate 2 sheets at a time in the center of oven. Preheat oven to 375°F.

Coat nonstick cookie sheets with cooking spray.

Mix together in a small bowl and set aside to soak for 10 minutes:
1 cup oat bran (dry, uncooked)
3/4 cup orange juice
Meanwhile, combine in a large bowl, using an electric mixer, until smooth:
1 cup + 1 T applesauce, unsweetened
2 T canola oil
1 cup honey
1/3 cup firmly packed brown sugar
3 lg eggs
1/3 T vanilla extract
1 T grated orange rind or 2 tsp orange extract

Measure into a sifter and sift over applesauce mixture:
1 ½ cups whole wheat flour
1 ½ cups all-purpose flour
1 T baking powder
1 tsp baking soda
Add the soaked oat bran and remaining ingredients to the large bowl and mix thoroughly with a strong wooden spoon:
1 cup nonfat dry milk
2 ½ cups oats (quick-cooking or old-fashioned)
1 cup nuts
1 cup raisins
1 cup ground flax seed (opt)

Drop by slightly heaping tablespoons 1” apart. (To save time, load cookie sheets up with as many cookies as possible, baking 2 trays at a time.

Stagger trays 1 to the left and 1 to the right, to allow air circulation around each outer edge.) Bake until lightly browned or 12 to 14 minutes.

Menu
2 Breakfast Cookies
Glass of Skim or Soy Milk

**Nutrition information for 2 cookies:**

<table>
<thead>
<tr>
<th>Calories</th>
<th>220</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calories from fat</td>
<td>29%</td>
</tr>
<tr>
<td>Fat (g)</td>
<td>7.7</td>
</tr>
<tr>
<td>Sat. Fat (&lt;1 g)</td>
<td>0.9</td>
</tr>
<tr>
<td>Fiber (g)</td>
<td>5.0</td>
</tr>
<tr>
<td>Cholesterol (mg)</td>
<td>22</td>
</tr>
<tr>
<td>Sodium (mg)</td>
<td>127</td>
</tr>
<tr>
<td>Protein (g)</td>
<td>6.0</td>
</tr>
<tr>
<td>Total Carbohydrates (g)</td>
<td>37</td>
</tr>
<tr>
<td>Sugars (g)</td>
<td>17</td>
</tr>
</tbody>
</table>

From Lickety-Split Meals
www.Zonya.com

---

Simplify your nursing research... with access to over 10 years of nursing publications at your fingertips. nursingALD.com

Simply click on the Newsletter tab on the far right and enter your search term.
Eliminating Patient Lifting Injuries Through an Effective Safe Patient Handling Program

by Elizabeth White, RN

Safe patient handling has begun to make its way to the attention of healthcare officials everywhere due to the high costs of staff injuries. However, their safe patient handling programs vary between simple “back” classes to teach body mechanics for caregivers, (which do NOT reduce injuries) to full equipment programs that lead to the complete elimination of patient handling injuries. Some programs work, and others don’t.

Every caregiver or nurse should be concerned with safe patient handling. If your facility has or is beginning a program, this article can shed light on what will work to lower worker compensation costs by reducing or eliminating patient care injuries. Nurses and caregivers should be aware that the trend of the future is to completely abolish with manual patient lifting and handling. All health care facilities should be addressing this enormous problem as basic staff support.

This article is directed to the perspective of a program director who has been assigned to reduce the worker compensation costs of the facility. The information could also be presented to administration, to encourage them to set up a program. It is completely possible to virtually do away with patient lifting injuries. Since any facility has to budget for workers comp, any person who takes on this task has a huge opportunity not only to prevent employee career life changing injuries (most important) but also to benefit their employer by saving large amounts of money. However, (and this is a large caveat!) throwing money at the problem won’t work, if you have not set up properly. Quite a few facilities have spent large amounts of money on equipment, only to see continuing injuries.

Administration

The first task is to ascertain whether Administration is just checking off a box on their list, or whether they are completely committed to eliminating injuries from patient handling. Their commitment can be ascertained by the support they are willing to provide. Without administrative support, you might as well pack it in from the start. Your program will never get off the ground. You will not have the budget or the administrative clout that is required to eliminate injuries. This is stating it bluntly, but history bears this out. However, explaining what is needed to your administration may help them change their position so they can truly assist in accomplishing this (admittedly enormous) task.

First, have a written plan of action. Following are suggestions to start:

1. Are they willing to give you the information you need in order to make a case for safe patient handling equipment? Will they give you authority to go to human resources and get information from them? You will need to know the amount of money the facility has spent in the past year or two on direct worker compensation. If they pay to an insurance company, (i.e., not self insured) then you will need to know the amount paid for insurance. Then, you can find out if that insurance company offers discounts to facilities that put Safe Patient Handling programs in place. Also, find out if your facility tracks where injuries originate. Inform your CNO that the actual costs are much higher when factoring in sick days, modified duty, replacement and retraining of workers.
2. Will they be able to provide you for a presentation on the Return On Investment (ROI) they would realize by purchasing Safe Patient Handling equipment? It would be good to have other C level officers there, in particular the Chief Financial Officer.
3. Will they be willing to budget the needed amount? You will need to realize that they have to do yearly budgets months in advance of the actual fiscal year, so it might take some time to purchase the equipment. However, an officer with enough authority can approve money that has not yet been allocated for this fiscal year (if they have any!).
4. Last but not least, once adequate equipment has been purchased, and training completed, would they be willing to make the use of this equipment mandatory? Remember needle stick injuries? Switching to the use of needleless systems was not optional. Though the outcome is not fatal, staff is far more likely to be injured lifting patients than to acquire a blood-borne disease.

Assessment of Needs

For each unit, make a list of patient handling tasks that are currently done manually. Many facilities have safe patient handling committees. The staff involved in these committees can be invaluable with their help in assembling this information.

The lifting tasks include:

1. Bed repositioning: boosting. When facilities keep track of what maneuvers are causing injuries, this is typically one of the most common.
5. Transfers to gurney.
6. Transfers to wheelchair or commode.
7. Assist to stand.
8. Ambulation assistance.

Note: Too often the bed repositioning functions are ignored because until recently effective equipment was not available. However, good equipment is now on the market. These functions must be addressed or the injuries will continue.

Make a careful list of equipment that will perform the manual tasks. This list should be made unit by unit, not as a blanket recommendation for the entire facility. Remember: NO MANUAL LIFTING IS SAFE! NO staff should be manually moving patients, even the “light” patients. This cannot be emphasized enough. Any facility that does not completely eliminate manual lifting will not see their injury rates go away. Now is the time when sales reps from different companies can be called to come in for demonstrations and trials. With the pricing given by the sales reps, make your equipment list with the cost. Remember that staff must be able to reach the equipment quickly or it probably won’t get used. Equipment should be either at the bedside (preferable) or in their line of sight as they look down the hall.

Visit www.stlukesonline.org

Manager Positions

Unit Support Team Nurse Manager
Heart and Vascular Services Nurse Manager
Learning Services Manager

Minimum Qualifications: BSN required. Previous experience preferred.

Duties and Responsibilities: The Manager is responsible for the day to day operations of the area/service/department. This includes the allocation of resources, efficiency and effectiveness of the area/service/department. The Manager reports to the Director of the area/service/department. There could also be a matrix reporting relationship to with appropriate departments.

St. Luke’s Magic Valley (Twin Falls, ID) offers a competitive compensation package and relocation assistance.

Visit www.stlukesonline.org

click on Careers

1. Are they willing to give you the information you need in order to make a case for safe patient handling equipment? Will they give you authority to go to human resources and get information from them? You will need to know the amount of money the facility has spent in the past year or two on direct worker compensation. If they pay to an insurance company, (i.e., not self insured) then you will need to know the amount paid for insurance. Then, you can find out if that insurance company offers discounts to facilities that put Safe Patient Handling programs in place. Also, find out if your facility tracks where injuries originate. Inform your CNO that the actual costs are much higher when factoring in sick days, modified duty, replacement and retraining of workers.
2. Will they be able to provide you for a presentation on the Return On Investment (ROI) they would realize by purchasing Safe Patient Handling equipment? It would be good to have other C level officers there, in particular the Chief Financial Officer.
3. Will they be willing to budget the needed amount? You will need to realize that they have to do yearly budgets months in advance of the actual fiscal year, so it might take some time to purchase the equipment. However, an officer with enough authority can approve money that has not yet been allocated for this fiscal year (if they have any!).
4. Last but not least, once adequate equipment has been purchased, and training completed, would they be willing to make the use of this equipment mandatory? Remember needle stick injuries? Switching to the use of needleless systems was not optional. Though the outcome is not fatal, staff is far more likely to be injured lifting patients than to acquire a blood-borne disease.
Business Case for Administration

Figure the previous year’s cost for patient lifting injuries. Start with the year’s cost of direct work compensation payments for medical care and injuries. If your facility tracks it, get the number of sick days out due to patient lifting injuries. Frequently a person with back pain will take 5 to 8 days off. Some sick time will not be claimed as worker compensation, even though the back pain is caused by excessive lifting loads. Find out how many workers had to be retrained; human resources should have this information, with the worker hours needed for the training. Find out, also, the costs for replacing an RN or CNA, and multiply this by how many workers needed to be replaced. Though this step is time consuming, you are far more likely to get budget approval if you can make this case with your administration. Realize that the ancillary costs of worker injury are usually three to four times the direct payments for work comp and medical care. Start with your total annual patient lifting injury costs, and divide that number by 12. Then, divide the monthly costs of injuries into the total cost of equipment. This will give you the approximate number of months until the Return On Investment. This does assume that the program can completely get rid of patient lifting injuries, if the program is implemented correctly.

How to figure:

<table>
<thead>
<tr>
<th>Total Annual patient lifting injury costs</th>
<th>Average Monthly Injury costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>

With this information, you can now go to your administrators and present the case to them for safe patient handling equipment. And remind them, that with a successful program, all that expense can literally go away for good. It will impact their bottom line for years to come. You might also want to mention that they will be spending the money either way: for equipment OR injuries.

If their budget does not allow for an entire hospital rollout of the program, convince them that the working on a unit by unit basis will show far better results than buying a few pieces of equipment and scattering them throughout the facility. That is somewhat worse than nothing. The equipment won’t be used, and the money will have been wasted.

Middle Level Management Support

Your unit managers are the most crucial element in a successful implementation of a Safe Patient Handling program. Bar none. The equipment won’t be used, and the money will have been wasted.

1. They will need to lead, and to inform the staff that this is not optional; they need to be using equipment for all patient handling functions. If the staff realizes how important it is to their manager they will follow.
2. They need to budget staff time for training on equipment. Usually this means bringing in a “break” person to relieve staff while they attend the training. They have to make training mandatory. If it is not mandatory, the change in culture simply won’t happen.
3. They, personally, need to take the time to be thoroughly trained on the equipment, so that they can train other personnel.
4. To save manager time, the manager needs to designate “super-users”, who will act as resource people to help and train all the staff in the regular use of equipment for patient handling. Often CNA/nurse techs make good super users. Because they are often the foundation for patient lifting they realize the importance of equipment.
5. The manager needs to work with the charge nurses. If equipment is in designated rooms, patients needing assistance with any kind of movement should be assigned to those rooms.
6. They should also know that typically patient satisfaction goes up, though there have been a few patients who refused equipment. If they object, patients also need to know that equipment is not optional because of injuries to caregivers.

Ongoing Support

Until no nurse has ever been taught that manual lifting is OK, ongoing reinforcement of the program will most likely be needed. I have seen facilities that fundamentally change and because everyone knows that “No-Lift” is the standard, they don’t need to emphasize it as much. Typically, Nurses are involved; they don’t like having to injure themselves in order to not injure themselves! The lifting must be completely eliminated, and then the staff will be more likely to adopt the use of equipment.

Middle level management are great selling points to nurses. Using equipment to move patients greatly increases patient dignity, as the large patients don’t have people gathering and whispering outside their door. Usually turning can be done with just one person, and perhaps one or two more for complex tasks. Pressure sores go virtually to zero, since patients can easily be turned every two hours. When patients have incisions or are injured, slow and steady movement done by motors is far better than “one, two, three, heave!”

A Note: there are several ways to convert to a true No-Lift facility. There are at least two devices that use regular bed sheets to repossession a patient. If your equipment uses slings for bed repositioning, you must leave the immobile patient on a sling for their entire stay. The slings can either be for a ceiling hoist or a mobile lift. However, staff should never be required to roll a patient on to the sling.

Adoption typically takes 90 to 100 days. Prior observation and experience shows that if the equipment usage is not made mandatory, the nurses won’t use the equipment enough to be comfortable with its use. (Brand and model don’t matter!) During this time, staff becomes more and more comfortable with equipment use, and after about three months resistance diminishes and equipment use becomes the standard. By this time, staff has usually realized that back aches and shoulder strains have greatly diminished and their quality of life has gone up.

Summary

A true No-Lift policy is possible with existing equipment. An effective Safe Patient Handling program must have the support of both administration and middle management. The administration needs to allocate funds for enough equipment and back up a mandatory policy. Unit managers need to effectively implement a plan, so that the education department needs to follow up with continuing education and testing. Increasing numbers of facilities are actually solving this ongoing problem and thus helping their bottom line, but most importantly preventing life altering injuries.

**Great news!** California now has a Safe Patient Handling law, which should virtually eliminate patient lifting injuries, as it requires facilities to make equipment available to all caregivers, or to have lifting teams available. California joins eight other states with safe patient handling laws.

Resources

For a summary of back forces, showing the incredible forces that produce the high rate of injuries, go to: [http://ergonurse.com/BackCompressionFlyer.pdf](http://ergonurse.com/BackCompressionFlyer.pdf). The second page shows lifting standards by NIOSH, and the realities of the lifting that health care workers do.

Elizabeth White, RN, graduated from BYU College of Nursing in 1976. She was injured as an ICU nurse, in 2003. As a result, she developed a bed repositioning system and has been involved in transitioning facilities to “no-lift” workplaces. She has personally witnessed facilities and units that have completely eliminated their patient lifting injuries.
When her children were grown, she went back to school and got her nursing degree. She worked as a nurse in the OB Department at Elko General Hospital for 16 years and loved it.

Julia Ficester—Passed away July 23, 2011. Julie was an Army Nurse Cadet during WWII in a military hospital where she attended wounded soldiers. After the war the family moved to Utah in 1948, where she continued working as a nurse at American Fork Hospital.

Patricia Olsen—Passed away July 31, 2011. During WWII she joined the Cadet Nurse’s Corp. Patricia worked for many years at the Holy Cross Hospital in Utah.


Agnes Leth—Passed away July 22, 2011. She attended nurse’s training at St. Benedict’s Hospital in Ogden, UT in 1946 and worked as a RN at St. Marks Hospital until she retired in 1987.

Eudora Clements—Passed away July 24, 2011. She graduated with an LPN from Utah Technical College and worked at the U of U hospital with the kidney transplant patients.

Nancy Farley—Passed away July 13, 2011. She worked all her adult life as a caring and knowledgeable nurse.

Mary Fitzgerald—Passed away August 15, 2011. Mary graduated as a RN from BYU in 1957 and received her masters degree in nursing from Wayne State University. She was a professor at UNLV for 34 years and served as president of the Nevada State Nurses Association from 1978-1980.

Willa Forward—Passed away September 15, 2011. She attended Utah Technical College to earn her LPN in nursing and at the age of 57 earned her RN and Bachelor Degree from Brigham Young University. She worked at LDS Hospital for several years before her retirement.

Isabell Thomas—May 20, 1909-September 14, 2011, She was 102 years old. Isabell earned her RN Degree from Holy Cross Hospital’s School of Nursing in 1931 and she was always proud of that achievement.

Ann Bruton Barningham—Passed away September 20, 2011. She graduated from the University of Utah College of Nursing, she worked in public health nursing for Salt Lake County. She obtained a master’s degree in nursing from New York University and then worked as the Director of the Associate Degree in Nursing from 1966-1970 at Brigham Young University. From 1970-1978 she served as the Director of Nursing Education for Intermountain Health.

Annette Nelson Brown—Passed away September 23, 2011. Lois graduating from St. Mark’s School of Nursing in 1957, Lois enjoyed her career and held many responsible positions. Lois received the Dr. First Humanitarian Award in 1984 while working at Pioneer Valley Hospital and retired in 1999.

Kathleen Connelly “Kathy” Pyle—Passed away September 15, 2011. Kathy provided for her family working in Utah as a nurse in long-term care centers. Motivated to become a nurse by her own personal struggles, Kathy was more than an inspiration, dedicated to the nursing profession for over 20 years.

Charlotte Rasmussen—Passed away September 21, 2011. She retired from the U.S. Navy after 22 years of service as a Nurse.
### APPLICATION FOR MEMBERSHIP IN UNA/ANA

Please print this form, fill it out, and mail it to UNA. The address is at the bottom of the page.

**Today’s Date** __________  **Home Phone** ______________________
**First Name/Last Name** ________________________________________
**Credentials** _________________________________________________
**Street or P.O. Box** ___________________________________________
**City** __________  **State**   __________  **Zip** ___________________
**Email** _______________________________________________________
**RN License #** _______________________________________________
**Basic School of Nursing** _______________________________________
**Referral By:** ___________________________________________________

**Employer Name** _______________________________________________
**Employer Address** ___________________________________________
**City** __________  **State**   __________  **Zip** ___________________
**Membership Categories** _________________________________________

**Membership**: Employed full or part-time

<table>
<thead>
<tr>
<th>Reduced Membership</th>
<th>Special Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not employed: full-time student; or new graduate within six months after graduation from basic nursing education program</td>
<td>62 years of age or over and not employed, or totally disabled</td>
</tr>
</tbody>
</table>

**PAYMENT OPTIONS** (Choose either Annual or Monthly)

**Annual Payment:**
- Full $253.00 / year
- Reduced $226.50 / year
- Special $63.25 / year

**Monthly Payment:** (Electronic Funds Transfer for Checking)
- Full $21.58/month
- Reduced $19.04/month
- Special $5.77/month

**Details:**
- The ANA will automatically deduct membership dues from your checking account. Dues transfer on approximately the 15th of each month. A check must be submitted, payable to UNA for first month’s amount to initiate transfer. Dues deductions will continue on a month-to-month basis until UNA/ANA receives notification to stop deductions.
- ANA is authorized to change the amount giving the above-signed thirty (30) days written notice. You may cancel authorization upon receipt of ANA of written notification of termination twenty (20) days prior to deduction date as designed. A $50 service charge is included in figuring monthly payments. By signing the form, I agree to these conditions.

**For Office Use Only**

- Date Rec’d __________________
- District __________________
- Paid Thru __________________
- Anniversary _________
- Data __________________

- Please return this completed application with your payment to UNA, 4505 Wasatch Blvd., #330B, Salt Lake City, UT 84124

**Becoming a “Friend of Utah Nurses Foundation”:**
- I would like to receive further information about the Utah Nurses Foundation; an organization dedicated to awarding scholarships and research awards to nurses in Utah since 1979.
- I have enclosed the amount of ______ $ ______ for the Utah Nurses Foundation with my membership application.
- If you choose to pay membership dues by electronic funds transfer, you must send a separate check for your donation.

**Utah Only Member Application**

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Work Phone</th>
<th>RN License #</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specialty/Practice Area**

**PAYMENT OPTIONS:**
- Annual Payment $1200.00 Annual Payment Method
- Check Enclosed
- VISA/Mastercard (circle choice)

**Payment Options**

<table>
<thead>
<tr>
<th>Card Number</th>
<th>Exp. Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature**

If you desire membership in the local state association without affiliation in the national organization you may now join the Utah Nurses Association directly through our Utah Nurse Association Member Organization.

---

**AN A RELEASES NEW SOCIAL NETWORKING PRINCIPLES**

**Utilizes social media to inform nurses about guidelines**

**SILVER SPRING, MD—** Given the pervasiveness of social media, the American Nurses Association (ANA) has released its Principles for Social Networking and the Nurse: Guidance for the Registered Nurse, a resource to guide nurses and nursing students in how they maintain professional standards in new media environments.

“The principles are informed by professional foundational documents including the Code of Ethics for Nurses and standards of practice. Nurses and nursing students have an obligation to understand the nuances, benefits, and potential consequences of participating in social networking,” said ANA President Karen A. Delay, PhD, MPH, RN, FAAN. “These principles provide guidelines for nurses, who have a responsibility to maintain professional standards in a world in which communication is ever-changing.”

The number of individuals using social networking is growing at an astounding rate. Facebook reports that there are 150 million accounts in the United States while Twitter manages more than 140 million ‘tweets’ daily. Nurses face risks when they use social media inappropriately, including disciplinary action by the state board of nursing, loss of employment and legal consequences.

AN A’s e-publication, ANA’s Principles for Social Networking and the Nurse provides guidance to registered nurses on using social networking media in a way that protects patients’ privacy and confidentiality. The publication also provides guidance to registered nurses on how to maintain, when using social networking media, the nine provisions of the Code of Ethics for Nurses with Interpretive Statements; the standards found in Nursing: Scope and Standards of Practice; and nurses’ responsibility to society as defined in Nursing’s Social Policy Statement: The Essence of the Profession.

This publication is available as a downloadable, searchable PDF, which is compatible with most e-readers. It is free to ANA members on the Members-Only Section of www.nursingworld.org. Non-members may order the publication at www.nursebooks.org.


Non-members $3.95

Members: Free

In addition to the principles, ANA has developed a downloadable (pdf) as well as several opportunities for discussion and discussion boards related to social media including a day-long Facebook discussion on Sept. 16, and a Twitter chat Sept. 23 at 1 p.m. EDT, (#anachat). ANA is also conducting a social media webinar scheduled for Oct. 25 featuring Nancy Specter, PhD, RN, director of Regulatory Innovations for the National Council of State Boards of Nursing (NCSBN) and Jennifer Mensik, PhD, RN, NEA-BC. ANA board member and administrator for Nursing and Patient Care Services at St. Luke’s Health System in Boise, ID. Additional details and sign up information about the webinar will be available on ANA’s social networking page.