Beginning the Conversation: The Nurse Educator’s Role in Preventing Incivility in the Workplace

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Recently, a young, disillusioned nursing student shared the following story:

“It was terrible. On my first day of clinical I was assigned to a patient with contact isolation. I was preparing to enter the room to take the patient’s vitals and I was unsure of what equipment may already be in the room. I asked the nurse assigned to the patient if the oxygen saturation device was in the patient’s room or if it was something I had to find elsewhere. He looked at me and said sarcastically “I don’t know, is it?” He was very rude and was no help at all. His reaction shocked me–he made me feel stupid and incompetent. The experience made me very reluctant to ask for help from him or anyone else. In the future if I have a question, I will do my best to find the answer on my own.”

While this student’s perception is troubling on many levels, the sad fact is that many nurses would acknowledge having a similar experience, either as a student or as a nurse in practice. It is equally important to note that examples of this type of uncivil behavior can also be found within the academic setting between teacher and student, as well as student to student. As educators, we view this student’s perception as illustrating one point along the continuum of incivility in nursing practice. As an illustration, if we were to plot incivility on a continuum, the far left point represents annoying, irritating, or disruptive behaviors such as rude comments, put-downs, or dismissive gestures like eye-rolling or staring. As one progresses along the continuum to the right, uncivil behaviors escalate to bullying, intimidation, and psychological abuse. The far right of the continuum includes threatening and potentially violent behaviors, up to and including aggressive physical violence and homicide.

Though all nurses in practice have a responsibility to foster civility, the purpose of this article is to discuss the role of nurse educators in raising awareness in pre-licensure students about the continuum of incivility, giving them tools to address uncivil behaviors, and beginning the conversation about creating a culture of civility. We believe it is critical to raise awareness about the continuum of incivility in future nurses in order to prevent escalation of lesser degrees of uncivil behavior to more destructive forms of lateral violence.

Overview of the Problem
Rowell (2010) defines lateral violence in nursing as any inappropriate behavior, confrontation, or conflict ranging from verbal abuse to physical and sexual harassment between colleagues. It is important to note that interactions that occur during the student’s education will shape his or her professional image. Nursing students observe how other nurses behave, both in education and practice, and thus develop a professional image. Nursing students observe how other nurses behave, both in education and practice, and thus develop a professional image. It is equally important to note that examples of this type of uncivil behavior can also be found within the academic setting between teacher and student, as well as student to student.

Recent research by Randle (2003) empirically demonstrated that when nursing students observe uncivil behavior in practice they are more likely to engage in such behavior themselves. Thus, it is critical that nurse educators in raising awareness in pre-licensure students about the continuum of incivility, giving them tools to address uncivil behaviors, and beginning the conversation about creating a culture of civility. We believe it is critical to raise awareness about the continuum of incivility in future nurses in order to prevent escalation of lesser degrees of uncivil behavior to more destructive forms of lateral violence.
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INA welcomes the following new members who joined July 1–August 31, 2010:

Kirt Adams
Terri Binkley
Carrie Bowman
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Mary Ruth Hassett, PhD, RN-BC

Author Note
Mary Ruth Hassett, PhD, RN-BC, is a member of the RNI Editorial Board and a Board Certified Informatics Nurse (ANCC). Hassett retired from Lewis-Clark State College where she was Professor and Chair, Division of Nursing & Health Sciences, and taught Nursing Informatics.

My 2007 laptop computer (HP Pavilion dv9000) came loaded with the Microsoft Windows® Vista Business operating system. Articles about the new Microsoft Windows® 7 operating system began to appear last summer. My husband Mike upgraded his work station to Windows 7 and told me it was time to do the same. I replied “Why Windows 7? My Vista works fine.” (He knows whenever it is time to upgrade software, I procrastinate. While writing my dissertation, I kept using WordStar 4.0 instead of changing to Microsoft Word.) Mike remarked that my laptop was sluggish. I frowned. He shrugged and left our office.

OK. I was scared. Maybe I would lose work files. Maybe my other software would get messed up. I frowned some more. Then I carefully read the articles. Windows 7 was described as a “big improvement over Vista” and the upgrade from Vista “a fairly easy, straightforward process” (Mossberg, 2009). Reviewers noted that Windows 7 took much less time to start up and shut down than Vista (Scheck & Wingfield, 2009). And Windows 7 creates Libraries, where the user may define collections of folders that enable faster searching in Windows Explorer (Kiriaty & Fliess, 2009).

Mike’s upgrade was from Microsoft Windows® XP. Mossberg called the upgrade fro XP to Windows 7 “painful” (2009). Mike described the process as “non trivial.”

Microsoft has a free “Easy Transfer” that I could have used (Windows 7 Features, 2010). A bug check error screen displayed by the Windows operating systems indicating a critical error.

References

Happy Holidays from the Board & Staff of the Idaho Nurses Association
The impact of incivility has significant implications for organizations employing newly-graduated nurses. Griffin (2004) found that 60% of nurses new to practice leave their first positions within six months because of some form of lateral violence, often occurring between the new nurse and his or her preceptor. According to Griffin, the relationship between the new nurse and the preceptor starts to break down. The new nurse stops asking questions of the preceptor and may eventually leave because he or she does not believe safe care is being provided. This type of scenario is reflected in the opening vignette.

Incivility and disruptive behavior in the nursing workplace are becoming more commonplace (Brown, 2010) and are frequently ignored (Lewis, 2006). These behaviors can compromise patient safety and, in part, have led The Joint Commission (2008) to release a sentinel event alert calling for zero tolerance to intimidating and bullying behaviors, implementation of a code of conduct for all employees, and an organization-wide approach to address disruptive behavior in the workplace.

Clearly, incivility is a problem in nursing practice, but nursing education is not immune to instigating and perpetuating the problem as well (Clark, 2008, 2008b). Nearly a decade ago, Ashley and de Menezes (2001) found that incivility had increased over the previous five years. Faculty reported students were tardy, leaving class early, and talking in class. More serious behaviors included cheating, yelling at faculty, and objectionable physical contact. More than half (52.8%) of the faculty respondents reported being yelled at in the classroom, 42.8% reported being yelled at in the clinical setting, and 24.8% reported objectionable physical contact by students. The authors concluded that disrespecting, yelling at, and threatening faculty and other students have become a serious problem. Shortly after this study, Thomas (2003) examined nursing student perceptions of faculty incivility and found that nursing students believe that nursing faculty members play a significant role in academic incivility including being rigid, acting superior, behaving defensively, and treating students unfairly.

**Beginning the Conversation: The Role of the Nurse Educator**

The importance of effective communication cannot be underestimated. Raising awareness about the existence and subsequent dangers of incivility and lateral violence, along with teaching nurses to ask questions and address the problem behavior, can reduce its incidence and effects (Griffin, 2004). So, how do we get the conversation started—and how can we sustain the dialogue once it has begun? We believe these critical discussions begin with and must continue throughout a student’s nursing education. While it is essential to teach our students about the importance of communication and conflict negotiation, it requires more than discussion. It requires repeated simulating, demonstrating, practicing, and rehearsing these fundamental skills.

**Conversations Among Faculty**

Because it is impossible to separate education from practice in the profession of nursing, we realize that conversations about incivility must begin early in a student’s education, rather than delaying them until the nurse enters the workforce. Before addressing practice issues with students, we also believe it is imperative that nursing faculty begin to have the same conversations with each other and as members of a faculty. Conversational topics among faculty should include:

- Do our institutional vision and mission statements, as well as our internal vision, mission and philosophy statements, reflect a commitment to civility?
- Have we established norms of acceptable professional behavior that outline how we interact with one another, as well as our students and community partners?
- Have we developed safe and respectful processes for holding oneself and others accountable for these norms?
- Do we incentivize or reward civil and collegial behaviors as well as role-model them for our students?
- Do we have clear and transparent processes for initiating a report of incivility and remediating founded complaints of uncivil behavior?

**Conversations With Students**

The conversations with students must be multi-layered and progress sequentially throughout their education. Conversations on civility begin early in the curriculum with discussions on introductory issues, such as university and school of nursing norms, culture and codes of conduct. As the student begins foundational courses, the discussion moves to professional ethics, codes of conduct, and regulatory standards such as State Board of Education statutes and guidelines set by governing bodies for schools of nursing. Students and faculty at this level begin conversations about early practice concerns, such as respectful communication with patients and peers, and the impact of cultural issues on care delivery. The role of the faculty member is to set expectations for students’ professional behaviors, but also to set guidelines for the behaviors students should expect from others in the workplace. It is essential for students to clearly identify uncivil, unacceptable behaviors, especially the more subtle, corrosive behaviors on the left side of the incivility continuum, which have been labeled—and tolerated for years—with the cliché of “nurses eating their young.” Nursing students must become familiar early in their education with the policies regarding uncivil behaviors in their clinical agencies.

**Nursing Curricula**

As students move through the curriculum and focus on care delivery at the bedside, faculty must embed readings on topical issues into course content. Violence in healthcare settings is front page news today, and students should be reading about and discussing these issues with their peers and faculty members. In the clinical setting, post-clinical debriefings and assignments incorporating self-reflection can be used to bring attention to incidents that reside along the incivility continuum. Post-clinical discussions provide students with a safe place to relate their experiences, share their emotions, receive constructive feedback, and learn appropriate ways of managing such situations within agency policies.

An important aspect of each student’s education is to provide him or her with the tools needed to function effectively as a nurse, to develop skills that will help them maintain their professionalism. In the clinical setting, post-clinical debriefings and assignments incorporating self-reflection can be used to bring attention to incidents that reside along the incivility continuum. Post-clinical discussions provide students with a safe place to relate their experiences, share their emotions, receive constructive feedback, and learn appropriate ways of managing such situations within agency policies.

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Beginning the Conversation continued from page 5

Suggestions for Meaningful Conversations

In closing, several suggestions are offered for engaging
in meaningful, critical conversation with others. At the end
of the day, it is the conversations we have with one another
which promote a culture of civility within our workplaces.

It is important to fully prepare yourself before engaging
in a critical conversation, especially when emotions are
running high. If you have experienced an uncivil encounter,
reflect on the experience, take time to cool off, and think
about your response. After careful deliberation, you may
choose not to respond at all. Ask yourself these questions: “If
I do not respond, what is the worst (or best) thing that can
happen?” “If I do respond, what is the worst (or best) thing
that can happen?” Once you have given careful consideration
to responding or not, in either case, put yourself in the other
person’s position. Consider how you may have contributed
to the problem, as this may help you develop a clearer
understanding and resolution of the issue.

If you decide to engage in a critical conversation, be sure to
close the potential barriers to effective communication,
including physical barriers such as noise or poor cognitive
abilities; emotional barriers in the form of anger, fear, or
feeling unsafe; or faulty reasoning or flawed assumptions.
Other barriers may include poorly expressed messages
(especially e-mail), time pressures, or misperceptions of
intent. It is best to eliminate as many barriers to a successful
resolution as possible.

Next, agree on a mutually beneficial time and place for
your interaction. Make sure the venue is quiet, undisturbed,
and away from activity; be sure to set aside plenty of time for
the interaction. If you are concerned about the outcome of the
meeting or uncomfortable addressing the issue alone, you or
the other person may wish to invite a third person to mediate
and provide perspective. Whether you go it alone or invite a
mediator, it is important to establish ground rules, norms, and
goals for the meeting.

Bearing in mind “the interest-based approach to principled
negotiation” developed by Fisher, Ury and Patton (1991),

If we focus on the person rather than the problem, emotions
become mixed into the situation, making the issues more
difficult to resolve. On the other hand, if we consider interests
and seek to negotiate matters important to each person, many
times the goals are compatible, and sometimes identical.

For example, consider the opening vignette. If the nursing student
and the staff nurse had engaged in a critical conversation and
used principled negotiation techniques, the common goal or
position each might likely take is providing safe, patient care.

By identifying a common goal, it increases the likelihood
that both are able to put personal issues aside and re-focus on
resolving the problem.

When we concentrate on interests [instead of focusing
on being right], it is easier to find opportunities for mutual
gain. This means generating workable solutions to the problem
that allow both parties to save face. Insisting on objective
criteria for fairness can be challenging. In our vignette,
ojective criteria might include searching for measurable
standards regarding required contact isolation items needed
in patient rooms, an inventory of the items posted on the door,
and acceptable ways of communicating and addressing one
another in a civil and professional manner.

Conclusion

Prevention of lateral violence in the workplace starts
long before an employee walks through the door. Civility in
healthcare organizations begins with teaching and modeling
civility for nursing students in both the classroom and clinical
settings. Objectives include equipping students with the
knowledge and skills for treating others with civility—and
also of how they should expect to be treated by others. The
overriding goal is that all nurses enter practice ready to work
collaboratively and effectively within organizations that have zero
tolerance for uncivil, disrespectful behaviors.

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Female Genital Mutilation: Cultural Practice or Human Rights Violation?

On April 26, 2010 the American Academy of Pediatrics (AAP) published its policy statement “Ritual genital cuttings of female minors” (Committee on Bioethics, 2010) sparking a firestorm of negative response from global organizations such as the World Health Organization (WHO) and United Nations agencies to denounce all practices of female genital mutilation (FGM) (End FGM Now, 2010). The strong responses lead to the AAP retraction of their policy on May 27, 2010. The information, discussions and outreach created by the controversy have served to broaden the awareness and efforts to eliminate these potentially lethal cultural practices.

Female genital mutilation or cutting refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical reasons (Obaid; Eliminating female genital mutilation, 2010). By adopting the term female genital cutting (FGC), many organizations choose to not alienate or demean the external aspect of women’s “ailments” such as lesbianism, epilepsy and mental health issues due to the trauma (Eliminating female genital mutilation, An interagency statement, 2008). According to the AAP, of the estimated 4 to 5 million procedures performed annually on female infants and children, the most severe types are performed in Somalia, Sudanese and Western Europe with clitoridectomy within the last sixty years (Obaid, p. 1). Obaid and others refer to the intrinsic cultural foundations and heritage of these practices. There is a strong sense of identity in countries practicing FGM/FGC, and their women are identified by their particular procedure. Many tribal men maintain the belief that unless a female has undergone FGM/FGC she has not been raised properly, nor is she marriageable. In communities where men control the economics, and women depend on men, parents will seek out FGM/FGC to ensure their daughter’s marriageability and survival (Committee on Bioethics, 2010). Female genital mutilation, 2010. Obaid. Although many groups site religious mandates for these procedures, the WHO has identified no religious foundations for these claims, and the procedures have been denounced by Christian, Islam and Jewish leaders (Eliminating female genital mutilation, An interagency statement, 2008).

These procedures carry untold consequences both medically and psychologically. Should a female survive, there are multiple long term consequences including increased risk of contracting AIDS, higher infant mortality and long term mental health issues due to the trauma (Eliminating female genital mutilation, An interagency statement, 2008). Despite international recognition as a human rights violation, and its identification as a punishable crime against women, FGM/FGC persists. Obaid identifies the need to “promote men’s understanding of their roles and responsibilities,” (p. 1) she sites the need for countries to eliminate discrimination, exploitation and violence against women, and work to promote equality and provide services for those females who have suffered due to FGM/FGC (Obaid). Lastly, the WHO response includes advocacy through the development of publications and tools; research to increase “knowledge about the causes and consequences,” (p. 3) methods effective in eliminating the practice, and care for victims; and providing guidance for health systems in the form of training, materials and guidelines (Female genital mutilation, 2010).

Realizing the number of females affected, the number of countries involved, and the individual communities participating in the practice of FGM/FGC, one must understand the multiple reasons these practices persist. The predominating cultural beliefs are central to controlling female sexuality and the male dominant role in maintaining community. The least destructive procedures are intended to decrease a female’s sexual desire and libido thus thought to promote virginity until marriage and then marital fidelity. Procedures closing the vagina are believed to promote chastity as well as increasing the husband’s pleasure during intercourse. Many communities view FGM/FGC as a girl’s entrance into womanhood. There are cultures who view the female genitalia as ugly and unclean. By performing FGM/FGC these females are seen as clean and beautiful (Committee on Bioethics, 2010; Obaid).

Obaid states, “The most important argument for performing female genital mutilation is that the female genitalia or other injury to the female genital organs is imperative to be culturally sensitive to those females who are living with effects and side effects of these practices. It is imperative to be culturally sensitive to those females who have chosen to have these procedures, and those who have not been given a choice, by not identifying them as having mutilated genitals, something that cannot be reversed.” According to the World Health Organization (WHO) FGM/FGC is classified into four major types: 1) Clitoridectomy 2) Excision 3) Infibulation 4) Other (Female genital mutilation, 2010). These procedures included in the fourth category also vary in severity and include piercing, pricking (drawing blood), scraping of the vagina, use of corrosive substances introduced into the vagina creating scarring that minimizes the vaginal opening, cauterization and incising (Committee on Bioethics, 2010; Obaid).

FGM/FGC is frequently performed prior to puberty, around 7 to 10 years of age, but based on cultural beliefs can be performed within days of birth, during childhood, adolescence, prior to marriage or during or after a first pregnancy (Committee on Bioethics, 2010; Obaid). Procedures are performed by traditional circumcisers, elderly persons designated by the community, traditional birth attendants, members of secret societies, herbalists, medical personnel and even barbers (Obaid; Female genital mutilation, 2010). According to Obaid, “FGM/FGC is carried out with special knives, scissors, scapels, pieces of glass or razor blades” (Obaid, p. 1). With the exception of procedures performed by medical personnel, anesthetics and antiseptics are generally not used. One personal account of a young women includes a description of being held down by five women for the procedure and having her legs tied by a rope following infibulation. She states that “the memory and the pain never really goes away” (Obaid, p. 1).

Historically, the origins of FGM/FGC are unknown, but there is evidence that FGM preceded both Christianity and Islam. Obaid describes “Egyptian mummies that display characteristics of FGM/FGC” (p. 1) and claims by historians that in the fifth century BC Phoenicians, Hitites and Ethiopians practiced female circumcision. She identifies that women’s “ailments” such as leshanism, epilepsy and mental disorders, among others, were treated in the United States and Western Europe with clitoridectomy within the last sixty years (Obaid).

Currently FGM/FGC is known to be practiced in 28 countries in Africa with an estimated 92 million girls age 10 years and above having had FGM/FGC performed there. Other countries in which FGM/FGC occurs include India, Indonesia, Iraq, Israel, Columbia, Peru and Sri Lanka (Eliminating female genital mutilation, An interagency statement, 2008). According to the AAP, of the estimated 4 to 5 million procedures performed annually on female infants and children, the most severe types are performed in Somalia and Sudanese populations (Committee on Bioethics, 2010). Migration throughout the world and resettlement efforts have brought the practice of FGM/FGC to countries like France, Britain and the United States (Gallard, 1999).
Update on Activities of the Idaho Board of Nursing

At their most recent quarterly meeting on July 22-23, 2010, members of the Idaho Board of Nursing considered business related to licensure, practice, education, discipline, communication, governance and organization. A highlight of the meeting was a presentation of “The Year in Review” (a synopsis of Board activities and accomplishments for the fiscal year just ended) and the “State of the Board” for the coming fiscal year 2011, anticipating initiatives and challenges for new fiscal year to include:

- Identifying and implementing requirements for demonstrated continued competence by nurses seeking licensure by endorsement, reinstatement and renewal
- Continued participation in the Nurse Licensure Compact and exploring the feasibility of adopting and implementing the APRN Compact
- Initiating statutory and rule revisions necessary for implementation of the Consensus Model of APRN Regulation
- Incorporating “just culture” in Board development, decisions and processes
- Developing the business plan for implementation of an alternative to discipline for substandard practice
- Commemorating the Board’s 2011 Centennial
- Enhancing communication and information sharing between and among constituents and key stakeholders
- Initiating paperless licensure strategies including necessary statutory and rule revisions
- Implementing strategies to conserve resources and protect the environment

Susan Odom, PhD, RN, Moscow, Chair, presided over the meeting. Other participating Board members included: Vicki Allen, RN, Pocatello; Janine Baxter, RN, Post Falls; China V. Gum, consumer, Boise; Jill Howell, RN, Jerome; Randy Hudspeth, CNS, NP, Boise, Vice-Chair; Shirlie Meyer, RN, Meridian; Carrie Nutsch, LPN, Jerome; and Rebecca Reese, LPN, Coeur d’Alene.

Consistent with their statutory authority to “evaluate, survey, review and approve nursing education programs”, the Board accepted the staff report of survey visit and granted continuing full approval for eight years to the practical nursing program administered by Idaho State University, Pocatello, accepted the staff report of survey visit and granted full approval for four years to the associate degree nursing program administered by Lindsey Wilson College, Boise; granted continuing full approval for one year to the nurse assistant training program administered by the College of Southern Idaho, Twin Falls, the College of Western Idaho, Nampa, Eastern Idaho Technical College, Idaho Falls, Idaho State University, Pocatello, Lewis-Clark State College, Lewiston, and North Idaho College, Coeur d’Alene; and approved the revised nursing assistant curriculum submitted by the State Division of Professional-Technical Education.

As a result of information presented by the Board’s investigator and prosecutor, the Board initiated formal disciplinary action against the licenses of 5 RNs, 2 LPNs and 1 APPN; approved the reinstatement of 1 formerly disciplined RN license; granted LPN licensure by endorsement based on equivalence to one applicant; and amended the restrictions on 1 APPN and 2 LPN licenses. In addition, the Board appointed Keith Davis, MD, Shoshone, to a continuing 2-year term on the Board’s Advanced Practice Professional Nursing Advisory Committee for the period ending June 30, 2012.

In preparation for the upcoming 2011 Idaho Legislative Session, the Board approved bill language to amend the Nursing Practice Act and Administrative Rules of the Board and directed staff to proceed with rulemaking and legislation. Proposed statute changes will allow the Board to share investigative information with other law enforcement agencies, including other Boards of Nursing. Rule changes relate to the definition of “family member”, delete redundancies, move selected rules to more appropriate sections, clarify who is allowed to administer medications and allow for paperless/electronic application processes.

The Board set tentative meeting dates for the coming year: November 4-5, 2010; January 27-28, 2011; April 7-8, 2011; July 21-22, 2011; and October 20-21, 2011. Board meetings will be held in Boise at locations to be determined and are open to the public. The deadline to submit agenda items for consideration at the Board meeting is approximately 30 days in advance of each meeting.
New Challenges For Nurses

by Dorothy M. Witmer, EdD, RN

Any nurse who responded to the invitation to register for the conference call on September 28, 2010 with First Lady Michelle Obama and Mary Wakefield, PhD, RN, FAAN, probably felt as I did, privileged to hear from these prominent women. Dr. Wakefield is the administrator of the Health Resources and Services Administration (HRSA) and is the highest ranking nurse in the administration (Idaho Nurses Association: Email admin@idahunurses.org, 9/24/10). The challenge to nurses was the substance of the discussion: educate patients about the new protections and benefits under the Affordable Care Act (ACA). Dr. Wakefield also discussed the many financial benefits to nurses who want to advance their education.

The First Challenge for Nurses

Michelle Obama preceded her remarks by relating her and her husband’s experience when their daughter, Sasha, who was only a few months old, was diagnosed with meningitis. Mrs. Obama and her husband were “scared” about their daughter’s prognosis but it “was the nurses” who helped them through the entire experience. It was the nurses who provided the support they needed. Mrs. Obama feels confident that nurses nationwide can be great communicators in helping patients to understand the restrictions on insurers and the benefits to consumers (personal communication, Michelle Obama, September 28, 2010).

Restrictions for Insurers and Benefits To Consumers.

Mrs. Obama and Dr. Wakefield spoke about the ACA restrictions on insurers and the benefits to consumers. Insurers can no longer: deny coverage to children with pre-existing conditions; put lifetime limits on benefits; cancel a policy without proving fraud; and deny claims without a chance for appeal. Consumers will be able to: receive cost-free preventive services; keep young adults on a policy without proving fraud; and deny claims without a policy of existing conditions; put lifetime limits on benefits; cancel a policy without proving fraud; and deny claims without a chance for appeal.

A Second Challenge For Nurses

Dr. Wakefield described another challenge for nurses when she reported on the many grants for nurse practitioners, nurse managers of clinics for underserved populations, and for nurses who want to pursue advanced degrees for teaching (personal communication, Mary Wakefield, September 28, 2010). For example, $31 million dollars have been designated to go to 26 schools of nursing to increase full-time enrollment in primary care nurse practitioner programs. Another $14.8 million will fund 10 grantees for 3 years to operate Nurse Managed Health Clinics (NMHC) in underserved areas. Nurses wanting to teach in a school of nursing may, from a school specifically funded for this purpose by Health and Human Services, receive a loan from the Nurse Faculty Loan Program operated by the school. If the nurse completes the program and teaches full-time as a faculty member, 85 percent of the loan may be cancelled. For information on all of the opportunities (and challenges), the interested nurse should go to two websites: https://hrsa.gov and search for grants:

www.hhs.gov/news/press/2010pres/09/20100927c.html that provides information on the loans available for advanced degrees for teaching. If there is difficulty in finding the desired information, the nurse should contact Rachel M. Conant, Associate Director of the Department of Government Affairs, American Nurses Association by phone: 1-301-628-5086 or by email: Rachel.Conant@ana.org. Rachel sent out the invitation to the conference call and responded to my email promptly.

First Lady Michelle Obama and Dr. Mary Wakefield provided a conference call that was exhilarating, informative and full of praise for nurses. The challenges now prevail: 1) educate patients on their rights and benefits and the new restrictions on insurers that are now in effect as a result of the Affordable Care Act; 2) take advantage if you can of the opportunities to advance your education as a primary care provider or nursing faculty member. Concluding remarks from Mrs. Obama and Dr. Wakefield included an increasing need for well prepared nurses as our population ages and more people need health care. Nurses will be needed in large numbers.

References:


Consumer Health Care Website on the Affordable Care Act: www.healthcare.gov/faw/information/index.html


Idaho Nurses Association. (2010). White House Call on Health Care Reform. Email: g2d@idahunurses.org

The Art and Science of Diabetes Education: Refining the Specialty of Diabetes Educators

Susan Iwasa
Gonzaga University

Challenges in providing education

Diabetes, a manageable condition in many circumstances, is growing at an alarming rate. An estimated 24 million people in the United States have diabetes. It is estimated today that 284 million people live with diabetes. (Wald, Roglic, Green, Sicree, & King, 2004). Following national trends of increasing prevalence, the percentage of Idaho adults with diabetes increased to a new high of 6.8 percent in 2005. Approximately 88,000 Idaho adults have diabetes. Many more do not know that they have diabetes. (Idaho Diabetes Prevention and Control Program website, n.d.)

Evidence and Benefits of Diabetes Self-Management

The evidence shows that diabetes education and self-management have a positive impact on the disease. Data from the 2005 Idaho Behavioral Risk Factor Surveillance System (BRFSS) show that people with diabetes who receive diabetes self-management training improve their management of diabetes. (Idaho Diabetes Prevention and Control Program website, n.d.)

Physicians and other healthcare professionals refer patients to diabetes educators for diabetes education that will augment the medical care they provide. (Idaho Diabetes Prevention and Control Program website, n.d.)

The Voice of a Diabetes Educator

I developed Type 1 diabetes just before the age of 30. It was a psychological blow. I found myself in the same position as people I had counseled with newly diagnosed diabetes. It wasn’t long before my personal and professional involvement in diabetes education and management grew into a full-blown passion, and it has been so ever since. The challenge of practice and an opportunity to be involved with helping people with their health care continues to be an important part of my nursing career.

Growing new diabetes educators

Diabetes patient education involves both knowledge-based and behavioral skills. It requires an education component that provides patients with psychomotor skills and cognitive ability to manage their disease. A certified diabetes nurse specialist possesses in-depth knowledge that provides new diabetes educators with the tools to perform diabetes education and management. At this level, the educator is not credentialed but continues to gain knowledge and skill through ongoing preparation and practice.

Levels 4 & 5: Clinical instruction and supervisory role

Credentialed diabetes educators meet the academic, professional, and experiential requirements established by the certification board. Competency in diabetes education or management is validated by means of written examination. Advanced/expert diabetes educators skillfully manage complex patient needs, assisting diabetes patients with therapeutic problem-solving, counseling, and regimen adjustments. At this level, the educator models and mentors others in clinical and program management skills.

There are three education accrediting bodies recognized by the CMS-AADE, the American Diabetes Association (ADA), and the Indian Health Service (IHS)- have adopted the National Standards for Self-Management Education (referred to as National Standards). (Funnell, Brown, & Childs, 2007)

The Multi-Level Diabetes Education Team

Success in a best patient care and diabetes self-management program comes from involving an extended diabetes education team. Higher level educators lead this effort. Currently, the American Association of Diabetes Educators (AADE) has defined a competency document that can guide the diabetes education team. Educators who are credentialed and/or have advanced skills can delegate some of the work to those educators who bring important competencies to the team.

The Multi-Level Diabetes Education Team

Level 1: Non-clinical instruction

This level comprises healthcare workers who do not have a clinical background, but who nonetheless work with persons with diabetes in supportive or clinical environments. As non-clinicians, there is no progression to further levels.

Level 2: Non-clinical instruction appropriate to the individual’s diabetes knowledge

This level encompasses clinicians who care for persons with diabetes in their general practice but who have not received specialized entry level training in diabetes disease management. These professionals may or may not progress to future levels. This is the entrance point to the specialty field of diabetes education.

Level 3: Clinical instruction

This level includes the clinician with several years of experience in the delivery of diabetes education. At this level, the diabetes educator is not credentialed and continues to gain knowledge and skill through preparation and practice.

Leve 4: Clinical instruction and supervisory role

Credentialed diabetes educators meet the academic, professional, and experiential requirements established by the certification board. Competency in diabetes education or management is validated by means of written examination. Advanced/expert diabetes educators skillfully manage complex patient needs, assisting diabetes patients with therapeutic problem-solving, counseling, and regimen adjustments. At this level, the educator models and mentors others in clinical and program management skills.

Stephanie Macon-Moore, BSN, RN Clinical Coordinator/Adjunct Clinical Instructor Pullman Regional Hospital/Walla Walla Community College INA Member since 2005

I am currently employed at Pullman Regional Hospital as a RN Clinical Coordinator. I also am a part-time adjunct clinical instructor at Walla Walla Community College–Clarkston Center for first year nursing students. I have been in these roles for 3 years and enjoy teaching very much. I am currently working on my MSN in Nurse Education at Western Governor’s University and will have completed the program in March 2011. I have worked as a RN for 12 years in acute care, critical care, long-term care and office nursing. In each of those roles I have learned a lot about nursing and I try to carry those teachings with each new adventure. I have recently become an INA District 21 delegate and volunteer on the membership committee.

In what ways has membership in INA been valuable to you?

I have been a member off and on since 2005 and over the past 2 years I have maintained my membership continuously and have become more involved over the last year because of the contacts that I have made with other INA members. I enjoyed reading the RN Idaho magazine and began to think “how can I become part of what is going on here?” So I attended the INA conference and started to get involved. I feel a great sense of connection with other Idaho nurses that I didn’t feel before and it’s great!

Why would you encourage other RNs to join INA?

I have worked with nurses from other states and it’s amazing how the nurses in those states work together to improve health in their communities and to improve their work environment. I would love to see that type of camaraderie here in Idaho. Idaho nurses are doing wonderful things in the state with research and volunteerism, but if we don’t connect with one another how can we help each other?

References


The team approach is a concept that is realized through collaboration and linkages with health care providers of other disciplines outside of the program. A full discussion can be found in the 2009 AADE Guidelines for the Practice of Diabetes Self-Management Education and Training (DSM/E/T) that defines these levels and describes some of their roles and responsibilities. (AADE, 2009)

Summary

A diabetes nurse specialist needs to depend on a competent educator team to care and teach patients with diabetes. We are living in a time of continual process and change. All elements of health care are in a process of reinvention and we nurses are a part of that evolution. Success will come by adapting the traditional model of diabetes self-management and training (DSM/E/T) to meet the ever increasing need of people with diabetes by extending the diabetes education team.