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NNA District 1 Legislator Meet and Greet

By Teresa Serrat, RN, Ph.D., NNA Legislative Committee Co-Chair

On August 18th the members of NNA District 1 (Northern) hosted a Legislative Meet and Greet at Willow Springs Outpatient Center in Reno, co-sponsored by The Nevada Dental Hygienists’ Association and the Nevada Physical Therapy Association. The event was held as a means for nurses and other health care providers to meet their legislators and legislative candidates and discuss the issues that are important to them. The opportunity to meet face to face not only allowed the nurses and other health care providers to speak of their experiences and concerns, but also for the legislators to begin developing a relationship that will allow them to solicit “real world” information and insight as pertinent issues arise during the legislative session.

Legislators and candidates in attendance included: Carol Fineberg and Sue Kozak for Sharon Angle and Susan Lisagor for Harry Reid (U.S. Senate), Jessica Sferrazza (Lt. Gov.), Brandi Anderson and Sharon Zadra (Reno City Council, Ward 2), Kevin Ranft

Meet Nevada’s Nurses: Betty Razor, RN, BSN, CWOCN & Martha Drohobycz, MSN, RN, CNM

In this issue, we recognize the achievements and service to the nurses of Nevada of Betty Razor, RN, BSN, CWOCN, District 1 President for 6 years, and Martha Drohobycz, MSN, RN, CNM, District 3 President for 4 years. Martha will finish her term in October and Betty next year. Story page 16.

“Betty and Martha, as District Presidents, have both shown unyielding dedication and leadership for NNA. Betty and Martha have always been there for NNA, our members and for me while serving as President, even when no one else could and I truly thank both of them for their support and contribution to NNA as District Presidents.”—Tracy Singh, JD, RN

President’s Address

By Tracy L. Singh, RN, JD President, NNA

It is with a heavy heart that I submit my last President’s Address as my term comes to an end. I have thoroughly enjoyed serving as President for the Nevada Nurses Association and I will continue to serve our members as Past President by leading and supporting various NNA committees and as an ANA Bylaws Committee member. I look forward to continued growth in the future for NNA with our new leadership and will support our new President in any way I can.

Hopefully, you are receiving this newsletter before the NNA Clothing Swap & visit by ANA President, Karen Daley on October 11th and the NNA Convention to be held on October 22-23, 2010. We invite everyone to join us for these fabulous events. For locations & other details, please visit our website, www.nvnurses.org.

I also want to remind all faculty and students about the 2011 NNA Student Nurse Competition which is already underway. Submit your intent to participate as soon as possible and get ready for the finals! For more information, visit our website or contact me at tsingh@tlsinghlaw.com. This is a unique and valuable opportunity for all students who participate. Help support our future leaders by encouraging all nursing students to participate.

Finally, we have begun structuring our NNA New Nurse Special Practice Group and all NNA members are invited to participate either as a “New Nurse” (less than 5 years in practice), or as a “Mentor” (more than 5 years in practice). Again, find more information on our website about all activities and events.

Join NNA/ANA today…Be Informed…Get Involved…Stay Connected!!!

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Nevada Nurses Association News Page 3

Visit us online at www.nvnurses.org

Join NNA today!

Membership application available online

current resident or CANDIDATE SURVEYS PAGES 10-14

LEGISLATIVE UPDATE, CANDIDATE LOCATOR PAGE 8

VOTE
Are you interested in submitting an article for publication in *RNFormation*? Please send it in a Word document to us at nvnursesassn@mvqn.net. Articles should generally be 250 to 1500 words, although exceptions are made depending on content. Our Editorial Board will review the article and notify you whether it has been accepted for publication. Articles for our next edition are due by December 1, 2010.

If you wish to contact the author of an article published in *RNFormation*, please email us and we will be happy to forward your comments.

**Correction**

The photo of the winning team from the University of Southern Nevada on page 1 of the August issue of *RNFormation* was incorrectly labeled as the team from USC.

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**NNA Mission Statement**

*MISSION*

The Nevada Nurses Association promotes professional nursing practice through continuing education, community service, nursing leadership, and legislative activities to advocate for improved health and high quality health care for citizens of Nevada.

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1999: Lobbied to prevent extensive scope of practice changes that would have dramatically expanded the scope of practice of unlicensed personnel in Nevada.

2001: Eliminated the growing practice of replacing registered nurses with lesser-qualified medical assistants in the public school systems. AB 1 required that school nursing be overseen by a registered nurse.

2001: SB 52 provided schedule two prescriptive authority for Advanced Practice Nurses in Nevada. This was a particularly important step to meet the needs of patients in rural settings with limited access to primary care services.

2001: Spearheaded successful worker's compensation reform legislation (AB 279) creating an automatic presumption that any nurse who develops a bloodborne disease after sustaining (and reporting) a workplace exposure is presumed to have acquired the infection from that work exposure.

2003: Participated in the creation of the Nevada Organ and Tissue Donation Task Force, which has since created public awareness and raised considerable funds for organ donation in Nevada. As a result of AB 53, assault on a healthcare worker in the course of carrying out his/her job is now a class IV felony in Nevada.

2003: (Special Medical Malpractice Session) Led efforts to introduce whistleblower protection legislation into Nevada statute to protect nurses who report healthcare practice that may harm patients treated in Nevada healthcare facilities. As a result of the efforts of NNA (and others), AB 187 did not become law.

2007: Spearheaded an effort to provide title protection for the title "nurse" to prevent personnel in Nevada from being able to use or even suggest that they were nurses without appropriate training, education, and credentialing. This important patient safety legislation allows those treated in Nevada physician’s offices and medical facilities to know when they are, indeed, being treated by a Registered Nurse.

2009: Led efforts to enhance previously legislated whistleblower protections to protect nurses who advocate for patient safety. AB 10 provides protections for nurses who report both internally and externally and reports to various government agencies (including the Nevada State Board of Nursing) are also included in the protection afforded by this law. AB 10 also creates a presumption that a nurse who is fired or subject to any sort of adverse employment action within 60 days of reporting an unsafe practice is the target of a retaliatory action.

2009: Worked with the Nevada Hospital Association to pass AB 121, which requires that each hospital in Clark and Washoe Counties create a staffing committee comprised of at least 50% direct care nurses. The committee recommends staffing procedures at each hospital unique to that hospital.

2009: Worked with other key stakeholders to pass AB 206, which included an amendment that acted as a companion bill to AB 10's whistleblower protections by requiring medical facilities that employ nurses to post in each facility the proper procedures that a nurse can follow to report unsafe conditions or processes.

2011 is going to be an active and important session for nursing in Nevada and much is at stake.

Your participation is essential. Please join our efforts by becoming a member of the NNA today! Participate in the Nevada Nurses Association Legislative Committee and help to shape the future of nursing in Nevada!
District One Report—Northern Nevada

November, December 2010, January 2011

Nevada had two poster presentations at the Annual Conference of the National Association of School Nurses in Chicago in June. Kathleen O. Hesse, RN, BSN, MAT, NCSN, School Nurse with Clark County School District, presented on her twenty-year experience with genetic clinics in the public school district. Her project described the collaborative work with Katrina Farwig, MS and Colleen A. Morris, MD. The CCSD Genetic Clinic process includes student selection by their school teams, evaluation in genetic clinic and the medical and educational follow-up of previously undiagnosed students.

Shelia Story, RN, BSN, MSN, MPH, Chief Nurse for Carson City School District and Karen D. Allen, RN, BS, CPHQ, Community Health Nurse for Carson City Health & Human Services Department presented: “School Based H1N1 Vaccination: A Successful Partnership.” Allen and Story, along with Marena Works, in creating and implementing School-based vaccination clinics for H1N1 immunization, discovered an effective way of administering vaccine to large numbers of children in the event of a community medical emergency. Their poster won the award for best practice poster presentation at the conference.

Also

Deborah J. Pontius, RN, BSN, MSN, NCSN, Chief School Nurse/Health Services Coordinator for Pershing County School District, was recently elected to the Executive Committee of National Association of School Nurses (NASN). Pontius has represented Nevada on the NASN Board of Directors. The March conference covered NNA District One’s obligation for the three 2010 nursing scholarships in our area. BUT... A long time NNA Member challenged nurses to match her donation of $300 by giving $10 or more each with the goal to increase the number of NNA scholarships. Give back to nursing and help those that could be your caregiver in the future. Donate now—do not wait.

G.I.N. Knowing that we can make a difference in this world is a great motivator. How can we know this and not be involved—Susan Jeffers

This fall the district will have a focus on GIN—Get Involved Now—with a call for committee volunteers to fill out vacancies. As nurses we are obligated to make a difference in the profession and in the health of our patients. There are many opportunities to G.I.N. and pass on your expertise, leadership and knowledge to others. Join the amazing group of volunteers in District One and give one hour a month as a committee member.

List of committees:

Membership: Welcomes new members, promotes membership, and coordinates activities with Student nurses

Hospitality: Recognizes members, acts as host (registration) at district events.

By-Laws: Reviews By-Laws and Policy and Procedure Manual annually for required revisions. Proposes changes to be voted on by members

Public Relations: Promotes all district and local nursing events with publicity, press releases.

Represents district at nursing schools and other events. Acts as official photographer.

Finance, Ways and Means: Coordinates the scholarship raffle on odd year. Coordinates silent auction at events as directed by the board.

Professional Practice/Education: Provides an all day CEU program in Spring of even year. Provides free CEU evening program 1-2 times a year

Nomination: Obtains candidates for elected office (June-Sept). Formats Ballot for electronic and USPS elections in October. Welcomes new elected officers.

Finally an INVITATION.

Come to the District One annual holiday awards and Installation of Officers dinner on Dec. 5 from 3-5:30 p.m. Look for your invitation. Come bring a friend or spouse for a fun time. Hope to see you all there.

Respectfully submitted,
Beatrice “Betty” Ramirez Razor
District One President

A special request: looking for a FREE site in Reno to hold NNA meetings. Any suggestions?

Congratulations

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District One President

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Congratulations, UNLV Summer Grads

The UNLV School of Nursing held its Summer 2010 Recognition Ceremony on Wednesday, August 18, 2010. Thirty-three students (pictured below) completed the requirements and will receive a Baccalaureate Degree in Nursing Science (BSN). In addition to recognizing the efforts of all the graduating students, at each of UNLV’s three yearly recognition ceremonies, special student awards are presented from the Dean and the Alumni Association. Recipients of the Summer 2010 awards for Academic Excellence, Leadership, Clinical Excellence, and the Spirit of Nursing were, Sarah Elmo Gomez, Edward Jason Aquino, Johnny Chua, and Emily Tidgewell, respectively.

Conference Focuses on New Nurse Transition to Practice

The Nevada Nursing Education and Practice Association, the Nevada State Board of Nursing, and Workforce Connections sponsored a nursing workshop, Grow Our Own Safe and Competent Nurses Conference—New Graduate Nurse Transition to Practice, on July 29 in Las Vegas and July 30 in Reno. The event was well attended in both Reno and Las Vegas. The keynote speaker, Nancy Spector, PhD, RN, Director, Regulatory Innovations, National Council of State Boards of Nursing, presented the NCSBN model for new nurse transition to practice. Other topics of interest included horizontal violence, nurse internship programs, and extended orientation. Dr. Spector’s power point presentation is available for download on the Nevada State Board of Nursing website.

Nevada Nurses Make a Stand

By Dee Riley, MSN, RN

“Do Nevada nurses want to take this one on?” asked the email I received from Sandy Summers, the Executive Director and founder of The Truth about Nursing. The Truth is a national non-profit organization dedicated to promoting an accurate and positive portrayal of nurses and the nursing profession in the media and advertising. Sandy had sent me a copy of an advertisement for a “Naughty Nurse” contest at the Jet Nightclub inside the Mirage Hotel in Las Vegas. The ad promised a cash prize to the person showing up in the “sexiest” nurse costume. When will advertisers EVER get over this one?

Some might call this harmless fun meant to increase business for the nightclub, but Ms. Summers and many others feel otherwise. “The global media’s relentless linking of sexual images to the profession of nursing reinforces long-standing stereotypes. Even though those images are often ‘jokes’ or ‘fantasies,’ the stereotypes they promote discourage practicing and potential nurses, foster sexual abuse in the workplace, and contribute to a general atmosphere of disrespect. Even humor and fantasy images affect how people act. That’s why advertisers spend billions on them,” states Ms. Summers on her Truth’’s website. Promoting the image of a nurse as part a sexual fantasy encourages young people from seeing nursing as a viable and worthwhile professional career choice. Over time this contributes to the nationwide nursing shortage, poor treatment of nurses at their places of employment, and failure of the public to take nursing seriously.

Being the co-president of the Nevada chapter of The Truth about Nursing, I agree that the “naughty nurse” promotion is detrimental to the nursing profession, so I decided to act. We only had two days, but I called a few nurse friends, designed and printed a poster, and drove over to the Mirage dressed in a white nursing uniform. I was sure we’d be thrown out of the Mirage in a few minutes being that it is private property, but we could go out on the sidewalk if we had to; someone needed to say, “Hey, we are nurses, and this is NOT ok.”

We stood outside of the entrance to Jet in white uniforms and scrubs, posters and pamphlets in hand to educate the public. Ok- we got a lot of stares and strange looks at first, but then people started coming over and asking what we were doing. We gave out our literature about the demeaning way nurses are often represented by the media, and how we are lowered to the level of nymphomaniacs for advertisers’ profits. People actually listened and said, “We are with you.” We had two nurses from Canada cheer us on and congratulate us on our courage for standing up for nursing. There was a group of California nurses in town who hugged us and took pictures of us to take home to show their colleagues. Police officers and other law enforcement professionals were also common admirers. “We support nurses,” they said. After about an hour, a plain clothed security guard quietly asked us to leave the Mirage. It’s probably not a good idea for hotel security to be seen throwing nurses out onto the street. We didn’t make a big fuss. We gathered our posters and pamphlets and went home. Carla suffers from chronic back and neck pain from years as a bedside nurse, and she had had enough by that time anyway. It was a small, not too loud protest, but we felt nothing but support. ‘Wish you would have been there.’

For more information about the work of The Truth about Nursing, see the website at http://truthaboutnursing.org/faq/naughty_nurse.html

Be Your Own Boss: Business Tips

Susan C. Knisely, BSN, RN
nursinginnovation@gmail.com

Collaborative teams are essential for business success. As health care changes through the recent passage of the health care reform bill, new opportunities will exist for nurses which include the ability to work in independent practice or through their own business. Good businesses never operate alone; they work within their organizations and with other businesses and individuals to ensure success through a process called networking.

In January 2010, I had the privilege of meeting Senate Majority Leader Harry Reid and Senator John Ensign at the US Capitol in Washington D.C. Our US Senators from Nevada as well as US Congressmen Dean Heller and Betty McCollum are strong advocates for nursing and our practice. I consider these gentlemen to be part of the team for nursing, allowing all of us the rights and abilities to advance our practice through policy

I would like to acknowledge three nurses whom I met through networking and with whom I developed a strong professional relationship through the years. They are not only excellent in their professional realm, but show a strong commitment to the lives of their fellow nurses as individuals. These nurses have the ability to progress nursing through innovation, advocacy and leadership. They are, Adrienne Szendre Stein R.N., Betty Razor R.N., and Jessica Carlson R.N.

As we all go through the changing times of health care reform, networking and team building will be essential. Do not miss your window of opportunity when it is at your front door. Do not shy away from it, be a part of the future.

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The origins and definition of evidence-based practice (EBP), as well as the state of Nursing’s readiness for EBP were presented in the previous RNFormation issue (August, 2010) as part I of this four-part series on EBP. In this issue, both classic and more contemporary EBP conceptual models are presented for you and/or your organizations to consider for your practice and research. The models (presented chronologically) include the Conduct and Utilization of Research in Nursing (CURN) (Michigan State Nurses Association, 1975-1980), the Stetter Model (Stetter & Marram, 1976; Stetter, 1983, 1985, 1994), the Iowa Model for Research in Practice (Titter et al., 1994), the Rosswurm and Larrabee Model (1999), the Academic Center for Evidence-Based Practice (ACE) Star Model of Knowledge Transformation® (ACE Star Model) (Stevens, 2004, 2005), and the Johns Hopkins Nursing EBP Model and Guidelines (Newhouse et al., 2007).

Often times, when the average nurse hears the terms ‘conceptual model’ or ‘conceptual framework’ they may think about their survey classes and how it relates to clinical practice, their personal strengths, and their relationships, used to help us assess, plan, and implement patient care by providing a framework within which we do our work. Likewise, EBP conceptual models are simply just depictions/diagrams of EBP concepts and their relationships which provide a framework for our practice, which, as most would agree, should be an evidence-based practice.

Unfortunately, the nomenclature used to discuss EBP Models or EBP in general is somewhat ambiguous. The terms “research utilization” and “EBP” are often used interchangeably, although they are not synonymous (Estabrooks, 1999). Research utilization generally refers to the application of scientific findings from primary research studies to practice. Evidence-based practice is more global and expressed the need for nurses to use scientific evidence from research studies to improve the quality of care in practice (Abdellah, 1970; Lindeman, 1975). By the mid 1970s, large research utilization projects developed several EBP models in the U.S which continued through the 1990s. In particular, the first four models (discussed briefly below) for research utilization can be considered the foundations for the initial understanding of EBP in nursing.

The Conduct and Utilization of Research in Nursing (CURN) project was developed in 1975-1980 by the Michigan State Nurses Association with support from the hospitals participating in the project. The purpose of the project was to use research-based knowledge in clinical practice settings. The research utilization process was stressed to be organizational with planned changes integrated throughout. The CURN model exemplifies structures, formal organizational processes that require organizational commitment, resources, and research expertise. The Stetter Model of Research Utilization applies research findings to the individual practitioner level and can be considered a vehicle for changing policies and procedures (Stetter & Marram, 1976; Stetter, 1983, 1985, 1994). The model has six phases and emphasizes critical thinking and decision making with the inclusion of nurses, educators, and policymakers, summarize research and use the knowledge to influence educational programs, make practice decisions, and impact political decision making (Burns, 1997). The Stetter Model steps are very practical in identifying research; these steps include preparation, validation, comparative evaluation, decision making, translation/ implementation, and evaluation.

Another of the more classic EBP models is the Iowa Model of Evidence-Based Practice to Promote Quality Care (Titter et al., 1994) which provides a framework for nurses to make decisions about day to day practices that effect patient care outcomes. More detail about this model is presented here because it is a widely used, very practical model for integrating research into practice; it is an outgrowth of the Iowa Model for Research in Practice (GAMUR) (Watson, Bulecheck, & McCloskey, 1987). Many nurses and organization adopt this model because its diagrammatic depiction is similar in function to a flowchart. The Iowa Model includes several feedback loops, reflecting analysis, evaluation and modification based on that evaluation of both process and outcomes; these are critical to individualizing the evidence to your practice setting. The Iowa Model begins by encouraging staff nurses to identify practice questions, triggered either through identification of a problem or through new knowledge. The practice question aligned with research findings, are then prioritized for allocation of supporting resources.

Once the topic is deemed a priority for the organization, a team is formed to develop, implement, and evaluate the practice change. The team is ideally comprised of stakeholders in the practice change, and may include the staff nurse(s) that identified the practice question, unit managers and advanced practice nurses, and interdisciplinary colleagues. Initially, the team selects, reviews, critiques, and synthesizes available research evidence. If the research evidence is not sufficient, the team can recommend using lower levels of evidence or conducting more research. If the evidence is sufficient, a practice change is initiated.

The team pilots the practice change to determine the feasibility and effectiveness. If the pilot results in positive outcomes, roll-out and integration of the practice is facilitated. This typically involves leadership support, education, and continuous monitoring of outcomes. Sharing project reports within and outside of the organization through presentations and publications supports the growth of an evidence-based practice.

(Continued on page 22)

November, December 2010, January 2011
Leading Nursing from Its Dark Side of History: Oppression
Mary Brann DNP, MSN, RN
Associate Professor, Touro University Nevada

Walking the nursing units of various facilities and talking to staff RNs reveals a dark side of nursing’s history: oppression. Nurse’s statements like “we are here to make the sick well, even though nurses work here” as well as a predominance of task orientation, horizontal violence, and a lack of engagement exemplify how nurses have lost a sense of profession through oppression. Just how the history of oppression has affected our profession will be revealed through a review of some of the literature along with suggestions as to how transformational nursing leaders can guide staff out of a culture of subjugation.

Understanding oppressed group behaviors has developed through observing the experiences of other oppressed groups. African Americans, Jews, and American feminists are but a few groups that have been cited in the literature (Roberts, 2000). Freire (1971) discovered that subordinate groups begin to dislike themselves and their group attributes due to dominance of another group that sets the norms for what is valued within the cultures. Nursing, historically, has been women held in a subordinate position to men (physicians). The traditional role of nursing supported medical practice and was closely linked to that typical role of women—caring for men in everyday life (Witt, 1992; Fletcher, 2006; Roberts, 1983). In the 1900s, physicians constructed nursing programs to serve them in their efforts to cure patients. Matheson (2007) stated that she set the groundwork for the oppressive relationship between the two professions. Further, the tendency for nurses to readily accept the medical model will help to emphasize that caring has been seen as an observable outcome of oppressive behavior patterning (Hedin, 1986).

Oppressed groups often adopt the values and attitudes of the dominant group as a method to improve their status and power. This typically does not empower the oppressed, but leads to lowered self esteem. Lowered self esteem leads to passive-aggressive behaviors in the presence of authority and is categorized as horizontal oppression. Organizational policies, programs, make practice decisions, and impact political decision making (Burns & Grove, 1997). The Iowa Model begins by encouraging staff nurses to identify practice questions, triggered either through identification of a problem or through new knowledge. The practice question aligned with research findings, are then prioritized for allocation of supporting resources.

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Nevada Association of School Nurses (NSASN) is the professional specialty organization for school nurses in Nevada. NSASN has been affiliated with the National Association of School Nurses (NASN) since 1991. Both have as their mission to “support the health and educational success of children and youth by developing and providing leadership to advance school nursing practice by specialized registered nurses.”

Currently 163 members belong to NSASN, which comprises about 65% of the school nurses in Nevada. “School nursing is a specialized practice of professional nursing that advances the well-being, academic success and life-long achievement and health of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety including a healthy environment; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self-management, self advocacy, and learning.” (NASN, 2010). One of NASN’s goals is to encourage the adoption of the school nurse to student ratio of 1:750 well children.

In Nevada, School Nurse is a protected title; one must obtain a school nurse endorsement from the NV Department of Education in order to practice as one. A Bachelor’s degree is required, either a BSN, or in another field PLUS either National Certification OR completion of a post graduate school nursing education program. Being a school nurse requires not only knowledge of pediatric health, but public health and special education law. With the influx of children with high medical needs in the school environment, there are also roles for other than bachelor’s prepared RNs in schools, AD/Diploma prepared RNs, LPNs and unlicensed assistive personnel work under the direction of a School Nurse providing high quality nursing care to our state’s pupils.

School nursing is considered expanded practice in Nevada. For example, a School Nurse may delegate oral medication administration to an unlicensed person, per the NV Board of Nursing “School Nurse Advisory Opinion,” which a RN cannot do in any other work environment.

School Nursing has a national specialty board, NBCSN, and 30 nurses in Nevada carry the title NCSN, or Nationally Certified School Nurse. Jeanine Clancy, RN, Med, NCSN is currently the Nevada representative on the national board of directors for NASN. She was also recently elected to the Executive Committee of NASN. Pontius lives and works in Lovelock and is the only school nurse for 4 schools and 750 students in Pershing County School District.

Debbie Pontius, RN, MSN, NCSN is currently the Nevada Director of National Association of School Nurses.  Debbie Pontius, RN, MSN, NCSN is currently the Nevada Director of National Association of School Nurses.  Membership in NSASN/NASN is open to not just school nurses, but to any person interested in promoting the health of school age children, including school nurse endorsement and the BON School Nurse Advisory opinion, please go to www.nevadaschoolnurses.com or contact NSASN at nasnnevadadirector@gmail.com.

### Nevada Nursing Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>American Association of Critical Care Nurses</td>
<td>(800) 899-2226 <a href="http://www.aacn.org">www.aacn.org &amp; info@aacn.org</a></td>
</tr>
<tr>
<td>American Association of Neuroscience-Northern Nevada Chapter</td>
<td><a href="http://www.aann-ncn.org">www.aann-ncn.org</a></td>
</tr>
<tr>
<td>Association of periOperative Registered Nurses</td>
<td>Ren Scott-Las Vegas or Sheila Hall-Reno (702) 383-7326 or (775) 445-8410 [<a href="mailto:renscottfeagle@gmail.com">renscottfeagle@gmail.com</a> or <a href="mailto:shelia.hall@fcthr.org">shelia.hall@fcthr.org</a>](<a href="mailto:renscottfeagle@gmail.com">mailto:renscottfeagle@gmail.com</a> or <a href="mailto:shelia.hall@fcthr.org">shelia.hall@fcthr.org</a>)</td>
</tr>
<tr>
<td>Hospice and Palliative Nursing Association in Northern Nevada</td>
<td>Nicolina Miller [<a href="mailto:hpna@hpna.org">hpna@hpna.org</a> or <a href="mailto:Nmillern-HPNA@hotmail.com">Nmillern-HPNA@hotmail.com</a>](<a href="mailto:hpna@hpna.org">mailto:hpna@hpna.org</a> or <a href="mailto:Nmillern-HPNA@hotmail.com">Nmillern-HPNA@hotmail.com</a>)</td>
</tr>
<tr>
<td>National Association of Hispanic Nurses</td>
<td>Maria Lipscomb (702) 239-9684 <a href="mailto:milpscombmr@aol.com">milpscombmr@aol.com</a></td>
</tr>
<tr>
<td>Nevada Association of Occupational Health Nurses</td>
<td>Nancy Menzel (702) 895-5970 <a href="mailto:nancy.menzel@unlv.edu">nancy.menzel@unlv.edu</a></td>
</tr>
<tr>
<td>Nevada Nurses Association</td>
<td>Margaret Curley (775) 327-9421 [<a href="http://www.nvnurses.org">www.nvnurses.org</a> &amp; <a href="mailto:nvnursesassn@mvqn.net">nvnursesassn@mvqn.net</a>](mailto:www.nvnurses.org &amp; <a href="mailto:nvnursesassn@mvqn.net">nvnursesassn@mvqn.net</a>)</td>
</tr>
<tr>
<td>Nevada Organization of Nurse Leaders</td>
<td>Susan Adamek (702) 995-0239 <a href="mailto:president@hnonl.org">president@hnonl.org</a></td>
</tr>
<tr>
<td>Nevada State Association of School Nurses</td>
<td>Jeanine Clancy or Debbie Pontius [<a href="http://www.nevadaschoolnurses.com">www.nevadaschoolnurses.com</a> or <a href="mailto:nasnnevadadirector@gmail.com">nasnnevadadirector@gmail.com</a>](mailto:www.nevadaschoolnurses.com or <a href="mailto:nasnnevadadirector@gmail.com">nasnnevadadirector@gmail.com</a>)</td>
</tr>
<tr>
<td>Philippine Nurses Association of Nevada</td>
<td>(702) 258-1224 <a href="http://PNANV.org">PNANV.org</a></td>
</tr>
<tr>
<td>Preventive Cardiovascular Nurses Association</td>
<td>Kim Newlin <a href="mailto:knewlinpcna@surewest.net">knewlinpcna@surewest.net</a> <a href="http://pcna.net">pcna.net</a></td>
</tr>
<tr>
<td>Society for Vascular Nursing</td>
<td>Kathy Ware (Sierra Chapter) 916-734-7701 or 888-536-4SVN (4786) <a href="mailto:svn@adminrare.com">svn@adminrare.com</a> <a href="http://www.svnnet.org">www.svnnet.org</a></td>
</tr>
<tr>
<td>Southern Nevada Black Nurses Association</td>
<td>Marcia Evans (702) 615-3575 or (702) 338-0524 <a href="mailto:www.snbna.net">www.snbna.net</a></td>
</tr>
<tr>
<td>Wound, Ostomy, Continence Nurses</td>
<td>Joyce Moss <a href="http://www.pct.org">www.pct.org</a></td>
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### Hospice & Palliative Nurses Association to Meet

The Hospice and Palliative Nurses Association will hold a meeting November 10, 2010, at the VA, 1000 Locust Street, Reno, in the Community Living Center’s conference room. Refreshments will be served. Students (CNA, LPN, RN) are welcome to attend.
This has been a particularly exciting time for the NNA legislative committee members as we’ve participated in several primary and general election activities. We hope you have found the time to explore what candidates in your district stand for and have to say. Those of you who had the chance to attend the Legislative Meet and Greet activities held in Las Vegas and Reno had a ‘one on one’ opportunity to meet some of the candidates and open a dialogue that is sure to influence the way the candidates respond to issues that are important to nurses across the state.

This is the last issue of the RNFormation prior to the general elections and we are pleased to present state senate and assembly district candidate responses to a nursing issues survey that was emailed to all the candidates in July. We sent out the requests to approximately 127 candidates and have compiled their responses for your review in this issue. It is important to note that some of the candidate responses have been edited down in order to meet the space requirements of this publication. Please be assured that the edits that were made did not obscure the original essence of the candidate’s response.

The full survey responses, which are available on our website (www.nvnurses.org), have been organized by each election race (senate and assembly district) and contain the candidates for each office. Additionally, the responses have been organized under the three priority issues for Nevada nurses: 1) improved access to care through autonomous practice for advanced practice nurses, 2) sufficient staffing for nurses to provide quality care to their patients and 3) safe patient handling to reduce injuries to patients and nurses. The last column contains the candidates’ general position on issues related to health care, nursing and what nurses can expect from them, if elected. Blank columns indicate issues that were not addressed by the candidate.

It is our hope that this information will help you in deciding which candidate will best represent you in the upcoming election. Due to the escalation in interparty and intraparty differences in recent years, there are some truly remarkable differences between the candidates running for several offices both within the state and nationally which makes this particular election especially interesting. Information included in this issue of RNFormation should help you decide on your choice.

Does your vote matter? As nurses, we should be particularly concerned that our opinions are heard and valued concerning health care. In Nevada, as in the nation, nurses outnumber all other categories of health care workers combined, so we can certainly have an influence if we exercise our power of numbers. The future of our health care will be decided by those we elect to make the decisions. Another area in which we are vitally interested is education. Some of us are educators and many others of us have children who will be participating in our educational systems. There are, in this election, some very different opinions among the candidates about how education should be supported and funded. We need to elect those who fit our opinions of how education should be handled.

Remember that, as stated by George Jean Nathan, author, editor, and critic,

“Bad officials are elected by good citizens who do not vote.”

Legislative Meet & Greet (Continued)

The Legislative Meet and Greet events help healthcare providers begin their involvement in the decision making process that leads to legislative change that can improve health care for Nevadans. We extend a sincere “thank you” to the legislators, candidates and health care providers who attended and helped make this event a truly meaningful and beneficial experience.

NNA Candidate Surveys

The following letter was emailed to all 2011 candidates for the Nevada State Legislators and all incumbent Legislators:

Dear Candidate for the Nevada Legislature,

The Nevada Nurses Association (NNA) would like to offer you the opportunity to introduce yourself and address the issues important to nurses across the State of Nevada. NNA is the professional nursing organization that is a supporting voice for over 37,000 nurses in Nevada. Currently, we are focusing on three areas of interest: 1) improved access to care through autonomous practice for advanced practice nurses, 2) sufficient staffing for nurses to provide quality care to their patients and 3) safe patient handling to reduce injuries to patients and nurses.

In the next legislative session, we will be actively pursuing legislative changes that will permit autonomous practice for advanced practice nurses in Nevada. While no legislative action is anticipated, we continue to monitor the issues related to safe nurse staffing and safe patient handling. We would like to hear your thoughts on these issues as well as your general position on issues related to health care, nursing and what nurses can expect from you, if elected.

Your response will aid your nursing constituents in determining the best candidate for the job and may be published in our quarterly newsletter that is distributed to all the nurses in the state. We thank you for your time and appreciate your efforts in addressing these important issues. We thank you for your willingness to serve.

The responses that were received are reported in the following chart. To view each individual candidate’s responses on a spreadsheet, visit our website at www.nvnurses.org. If you have questions for the candidates or legislators from your district, we encourage you to contact them directly. For help in finding your legislators, visit http://mapserve.leg.state.nv.us/website/lcb/viewer.htm

We thank the candidates for responding.
**District 27**

I really like this idea. On the surface this allows nurses to advance their pay and could potentially reduce healthcare costs should the nurses break free of the current constraints. The key is to ensure that the nurses are properly trained and regulated to ensure high-quality care.

---

**District 20**

**District 13**

**District 10**

**District 7**

**District 6**

**Assembly**

**Washoe 1**

**District 2**

Lerner, David (D)

I can support the changes that will permit autonomous practice for advanced practice nurses in Nevada. I will not support reducing the courses presently under consideration. As a professor for elimination in the nursing curriculum. As a practical matter the slogan adopted for my campaign “Commonsense in Politics” should be an indicator of what the Association can expect of me. It makes no sense to not utilize the trained talents available to assure proper and safe patient care. In the final analysis this is a win-win situation from a cost standpoint in keeping medical care costs in check.

**District 4**

Fisher, Gary (D)

With the shortage of healthcare providers in Nevada, I would support legislation that addresses autonomous practice for advanced practice nurses. Obviously, the details in this kind of legislation would be very important with protection of the public absolutely critical.

---

**District 5**

Dondoro Loop, Marilyn (D)

I would like to request more information on the autonomous issue. How do doctors and nurses work through this at the present? Nurses are very important in the day to day care of patients and I believe this is the utmost importance that all agree on this issue.

---

**Location**

**Candidate Names**

**Autonomous Practice for APNs**

---

**Senate**

Capitol

Ranft, Kevin (D)

Advanced nurse practitioners are highly skilled and can give patients access to health care without having to see a physician. It is my understanding that some nurses are experienced and well-educated on the needs of nurses in advanced nurse practice. I would like to provide care through autonomous practice, they should be allowed to offer this service for the areas in which they have experience and/or advanced training.

---

**Assembly**

Leslie, Sheila (D)

I support all three of your issues. I have submitted the bill draft for the autonomous practice bill. I believe this legislation will greatly benefit the public by providing more effective access to health care, especially in rural areas where medical professionals can be scarce.

---

**District 2**

Lerner, David (D)

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**Hambrick, John (R)**

Our health care system is going through many changes as a result of the new program signed into law this year. One thing we need to do is to continue to find ways to reduce costs while providing quality care. Having someone visit an advance practice nurse rather than see a doctor right from the start can reduce those costs while increasing access to quality care. It is a subject worth addressing and deciding to what extent it can improve Nevada’s health care system.

---

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---

**District 6**

Long, Carole (R)

I have great respect for the medical profession, my mother was an LVN and I know how hard she worked and how she strived to care for her patients, so I have an understanding of your desires. If I can help improve the ability of nurses to do their jobs in a safer and more efficient manner it would be my pleasure to do so.

---

**District 7**

Neal, Dina (D)

I am not familiar with autonomous practice. The issue is the action of working independent of the physician. My first thought is what is the liability and is the nurse who acts independently willing to take on that liability. I do not agree with a nurse operating independently if she is still covered by the physician’s insurance and prone to a lawsuit. There is a liability issue here.

---

**District 8**

Frierson, Jason (D)

With respect to improved access to care through autonomous practice for advanced practice nurses, I am interested in furthering the goal of improving the quality of healthcare effectively as well as efficiently. My mother worked at Martin Luther King, Jr. County Hospital in Compton, California when I was a child. My health is important to me and, as a nurse in constant contact with my, who is a nurse and a patient, California. They are a regular reminder of the importance of addressing improved access to such care. I recognize this involves specialized knowledge and I am looking forward to hearing more information about the implications associated with autonomous practice for such nurses.

---

**District 10**

Hogan, Joe (D)

I fully support greater reliance on the advanced skills of our many highly specialized nurses. The very pressing financial need for greater efficiency and control of costs for medical treatment, require a rapid expansion of autonomous practice to deliver needed services at affordable cost levels.

---

**District 13**

Desalvo, Louis (D)

I believe that this is an issue that needs to be addressed so that we can work towards providing the best healthcare possible in the most efficient way that we can, and I would be interested in hearing more of the pros and cons of both sides of this debate so that I may get a better understanding of the impact on nurses in Nevada.

---

**District 16**

Oceguera, John (D)

One of my greatest concerns is the state of available and affordable health care here in Nevada. With our current economic downturn, the situation has become even worse with more Nevadans finding themselves unable to afford medical care. If permitting autonomous practice for advanced practice nurses helps us address either the availability or affordability of health care, then I am inclined to support it.

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**District 19**

Wang, Jerry (R)

I am in complete support of autonomous practice for nurses.

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**District 20**

Hardy, Cresent (R)

Access to high quality health care is a major concern across the country, but especially here in Nevada. I believe that well-trained, safe advanced practice nurses should not be bogged down by overbearing rules and regulations. Nurses should be able to focus on their patients instead of worrying about a long list of convoluted regulations, and considering the amount of time they spend with patients, their input on the proper course of care is invaluable. Administrative interference should not dictate how care is delivered. Reducing the autonomy of nurses limits patients’ access to health care, so we should do all we can to improve access to care.

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**District 21**

McKay, Les (IAP)

Improved access to care through autonomous practice for advanced practice nurses: I have no problem with autonomous practice for advanced practice nurses. Advanced practice nurses are highly trained and, in most cases, are quite capable of taking the place of a primary care physician. Autonomous practice for advanced practice nurses is a great example of a market solution to the rising cost of health care. I much prefer a market solution by experts in the particular field. Very few politicians know anything about health care and have no business attempting to solve the problems of health care without external advice. The politician’s proper role in this case is to get out of the way and see what people who actually know something think.

---

**District 22**

Donovan, Kevin (D)

Having children, we visit the doctors’ office more than most. Usually it is an advanced practice nurse that is diagnosing our kids and prescribing medicine. My wife, who accompanies the children on most of these visits, feels the nurses do an excellent job with their thoroughness and even prefers them on many occasions.

---

**District 24**

Bobzien, David (D)

I look forward to reviewing your legislative initiative to increase patient access to care through autonomous practice for advanced practice nurses. I support increased access to quality health care and will consider the legislation from the perspective that quality of care and increased access must be in balance.

---

**District 26**

Taylor, Angie (D)

Although my knowledge in this area is limited, I am supportive of autonomous practice for advanced practice nurses as long as they possess the required knowledge and skill and that it applied in their scope of practice. I would be interested in learning more about this issue, especially as it relates to the satisfying work environment for the nurses and patient welfare.

---

**District 27**

Benitez-Thompson, Teresa (D)

I believe we should always be asking ourselves, “How can public policy optimize access to quality care in a timely fashion?“ I understand autonomous practice for advanced practice nurses is NNA’s response to this question. While I am not able to commit to a piece of legislation before I have read it, I do believe this is a plausible option that should be explored. I also understand the policy process moves incrementally, and that working to build the support for such a measure also happens incrementally.

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**Jurado, Gabe (R)**

Initial and continued patient contact patient is paramount when analyzing direct patient care. While on the Fire Department for the City of Reno I saw firsthand how crucial medical information was not passed on from an EMT to Paramedic and from the Paramedic to the ER Nurse and/ or Doctor. If only there was a better way to initiate and maintain one person as the contact for the patient and give that person increase control on how that person was treated. We have that ability now with Advanced Practice Nurses that are highly trained and capable to provide and make decisions for patient care before a physician even gets to take a look at the patient. Unfortunately state laws ties the hands of those nurses that are able and competent to give quality, direct and efficient care within their scope of practice. APN’s are the direct contact with the patient’s and can provide the best quality care and less vitals possible to the patient. The main reason I am running for office is my goal to ensure that the nursing personnel are given the full protection of the law against any and all possible lawsuits stemming from doctors prescribing actions and nurses being tasked with carrying out the action. In addition, I want to encourage all facilities, both private and municipal to recognize the nursing staff and value them.

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**Lale, Erin (L)**

I support autonomous practice for nurse practitioners. I am in favor of removing artificially imposed government barriers to high quality, affordable health care. There should be an improved pathway for former military nurses to enter civilian nursing practice at the same level of autonomy they have presently under consideration for elimination in the Nursing curriculum. As a practical matter the slogan I have adopted for my campaign, “Commonsense in Politics” should be an indicator of what the Association can expect of me. It makes no sense to not utilize the trained talents available to assure proper and safe patient care. In the final analysis this is a win-win situation from a cost standpoint in keeping medical care costs in check.

---

Please vote!
I support your concept of “Autonomous Practice for Nurses” and will work with you to help craft legislation that meets your goals. If, as many fear, ObamaCare will force many Family Practice doctors to retire or not go into family practice, there will be a need for trained nurses to provide basic patient care, and this concept seems a logical and affordable path to take.

I am not opposed to autonomous practices in theory; however, I do have concerns as to the reality of bringing them to fruition in a manner which will benefit the patient, while satisfying the stakeholders. These concerns include identifying the appropriate scope of practice, educating the public and the legal responsibility of such clinicians. As with expanding roles in any licensed profession, due diligence must be done to protect smooth implementation. Clearly defining what services and procedures can be provided is crucial. While advance practice nurses do have additional education and skills, their credentials are not recognized by all that much in the medical profession, and as such any autonomous practices would have limitations under the lack of a traditional doctor on staff. Some practitioners may not have the same comfort level with a nurse as a physician and must have all facts prior to any appointment. Another area of concern is that of liability. If an autonomously practicing nurse incorrectly or misses a diagnosis, which is later found by a physician, and the patient’s condition worsens, the question of liability becomes an issue. The concept of autonomous practices came out of the need to provide healthcare in our rural communities where physicians are scarce. And while they have proven to be an asset in these communities, implementing them in urban area may prove more difficult.

I am sure you will face considerable opposition to this measure from others, but I do believe we must become more innovative in finding ways to bring affordable healthcare to Nevadans. If providing more flexibility and autonomy to advanced practice nurses is shown to not increase the risk to patients, then this seems like a practical solution which I am inclined to support.

For more information on candidates, please visit their websites and/or call them or their campaign personnel.

For the latest news and information on health care issues, visit the Nevada Health Policy Institute at http://www.nevadahealthpolicy.org.

If you would like to contribute to the Nevada Health Policy Institute, please visit their website at http://www.nevadahealthpolicy.org/donate.

I support your concept of “Autonomous Practice for Nurses” and will work with you to help craft legislation that meets your goals. If, as many fear, ObamaCare will force many Family Practice doctors to retire or not go into family practice, there will be a need for trained nurses to provide basic patient care, and this concept seems a logical and affordable path to take.
In past legislative sessions I have supported safe nurse staffing as a common sense approach to making sure that patients are watched over carefully. During hospitalization there are those whose life or future health are at risk if not carefully monitored. Staffing must be adequate to provide that safeguard.

The national nursing shortage is of critical concern. Here in Nevada, where we held the distinction of having the highest shortage for many years, many factors contribute to the problem, including increased patient load, increased responsibilities, mandatory overtime, a waiting list to gain admission to the university nursing school, and inadequate wages. Burn-out is a very real problem. The need to keep nurses happy and patients safe is not exclusive of one or the other. Ultimately, I believe a community has to have both. Overworked, overtired, overstressed people are more likely to make mistakes, which can have devastating effects on the patients they care for. Hospitals suffer when their infection rates or patient fail rates go up and staff performance goes down. People who go into nursing must be cared for the way we expect them to care for us – with dignity, skill, and professionalism. So, yes, I believe that ideally, facilities should staff their units according to nationally recommended, professional nursing organization guidelines. Some people think this problem is going to resolve itself, and cite growing numbers of nurses in some states due to the successful recruitment of nurses from other countries. I believe the problem is going to get much worse now that health care reform is a reality. If we already have a hard time staffing hospitals with adequate personnel, how will we do with the American, Benign home care services, once they have coverage through the insurance exchanges? The problem is complex and far-reaching. It is both a statement of truth and an overall challenge, and we must find ways to ensure that we just decrease the nurse/patient ratio.

I continue to look forward to reviewing reports from the hospitals regarding nurse staffing ratios. While there is no doubt a lack of adequate nurse staffing can impact patient care, I also look forward to reviewing the need for flexible standards that flow into acute care and into long-term and acute care hospitals. That said, the legislature’s review of the reports will further our understanding of the issue here in Nevada, and additional legislation may be required in the future.

Each diagnosis has its own pathology, and within that each patient has a unique experience. No two cases are exactly the same, and often times even the most mundane cases go sideways quickly. Additionally, supportive staff, or lack thereof, such as CNAs, social workers and med techs must be accounted for. I understand the legislation took action in 2009 (AB1211), and I am interested to see what individual Staffing Committees have formulated.

I am in favor of minimal standards for staffing in the various areas of need (preparation, surgery, recovery, emergency, etc) as set by the state in corporation with nursing associations. There should also be consideration given to local needs – smaller rural locations versus larger urban facilities. As dean of extended education at UNLV, I had the job of supervising the 2-year certificate program in radiography. Providing the proper learning environment in the hospitals and meeting the requirements of an academic program involved the kind of negotiations that I support – involve those closest to the action.

I understand nurses concern with unsafe lifting practices. These practices cause injury to both the nurse and the patient. Nurses and other health care professionals have been working on this issue for the past several sessions. No legislation has been passed, although attempting to find a hard and fast solution to say that we should just decrease the nurse/patient ratio.

The people who work closest to the injuries are best suited to developing programs and training to reduce them. The people who work closest to the injuries are best suited to developing programs and training to reduce them.
In any work environment best practices should be identified and implemented to ensure maximum safety for both employees and customers. In the workplace, best practices will continue to attract the quality people that we see in the nursing profession today. Thank you for caring for us and our families.

Never before have we been in such critical need for caring people as we roll out a new system of healthcare delivery. It is my hope that the medical professionals will continue to attract the quality people that we see in the nursing profession today. Thank you for caring for us and our families.

I think that overworked nurses are more likely to make mistakes and have accidents. This puts them, their patient(s) and the colleagues at risk. Likewise, nurses need jobs. They care for us and our families. Nurses are vital to every aspect of health in Nevada; physical, mental, fiscal, and environmental. In any work environment best practices should be identified and implemented to ensure maximum safety for both employees and customers. In the workplace, best practices will continue to attract the quality people that we see in the nursing profession today. Thank you for caring for us and our families.

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District 10

Hogan, Joe (D)

Thank you for the opportunity to respond to the issues that are important to the nursing profession. My sister recently retired from a long and fulfilling career as a nurse in the Chicago area. I was aware of the ever increasing pride and confidence she displayed as she performed and gained new skills and advanced qualifications over the years.

District 15

Anderson, Elliott (D)

As for health care, the last thing I want to see is overworked nurses, and under-cared for patients. Guaranteeing quality, affordable health care is a critical challenge facing our legislature in the upcoming session. We must ensure that there are adequate staffing ratios to ensure quality patient care and safety. I look forward to working for and learning from Nevada's nurses and other health care workers on these important issues. I will always support the nurses, because I must assure nurses and patients are safe. I believe we must build health care providers that work every day for the people of Nevada. I will also generally support the efforts of advanced nurses to practice in preventative care.

District 16

Oceguera, John (D)

As I’ve said, I am deeply concerned about the state of health care in Nevada. We have too many citizens without health care coverage. We have stretched our resources thin by paying for emergency treatment instead of early access to medical care. We have too many young children at risk from preventable disease due to lack of well baby programs and adequate vaccination programs. We must come from a national debate on health care in America. Here in Nevada, we will continue to support good programs which provide better health care.

District 19

Wang, Jerry [R]

Throughout my life, I’ve only had to be in a hospital once due to severe pain in my back and left arm. It was an unpleasant experience, but from my own eyes I saw the doctors were too busy to help and listen to patients. It was the nurses that were the most attentive. After several tests that were ordered by the doctor, the results were still inconclusive. Because the tests were inconclusive, I was still in pain and stated that if I was his own brother, he would tie me down and not let me leave. It was a compelling statement, but I still chose to leave. I ended up with a $12,000 bill from the hospital in the late hours of the evening. I cannot imagine what the final bill will be. According to the nurses, there were several that were assigned to my bed. Each one listened to what I said, did their job as requested by the doctor, but they did not have authority to change my treatment or to override the doctor’s decisions. It is my opinion that nurses are the nicest people in the world. I can only imagine what nurses have to deal with every single day. It is not something that everyone can do or want to do.

District 22

Durbin, Sallie (IAP)

My husband, Master Sergeant Jeff Durbin is running for the office of Clark County Commissioner District F, if you visit his website you will see where you fought both houses of Congress to ensure the nurses who treat military veterans were given yearly COALAs. During his battle, I helped him, prepare the letters and sent them out to the editor of many newspapers throughout the country. He was finally recognized with it for his efforts. His website www.ElectAWarrior.org describes in more detail what occurred and I intent to keep on carrying out the agenda both we feel is necessary for the hard working of the nursing career. In addition, I will not tolerate nor condone nursing staff to be regulated to the ogni and bed pans when budgets are being crunches and nurses-CNAS which then requires the nurses to pull double duties, that of the doctor, the caregiver and miscellaneous other duties regarding patient care.

District 25

Townsend, Robert (D)

My general position re: Healthcare is “Medicare-for-All,” - a Universal Public Option. I fully support your stated goals. While ‘Healthcare’ is regarded, generally - as a Federal Constitutional Congressional issue, I believe that there are options that might make it possible to do for Nevada to establish our own health-insurance ‘exchange’ which could result in the creation of health-care cooperatives providing really substantive competition for the for-profit health industry. We still have a long way to go to provide access to affordable, quality healthcare for Nevadans; and my primary and overwork and professional protections for our providers - chiefly our Nurses, techs, and other ‘front-line’ healthcare delivery folks. Thanks for the opportunity to weigh in on this.

District 27

Benitez-Thompson, Teresa (D)

I am a first time candidate working hard to become acquainted with NNA's legislative goals. In my daily profession as a Licensed Social Worker, I have the privilege of virtually hospital care setting. I worked with many nurses in an inpatient setting. Often time, the RN and I are problem solving and working together to comfort families when they are emotionally distressed. I trust the nurses I work with implicity, and have the utmost respect for them. I am proud to call many of them my friends. If elected, I believe the NNA, and the 37,000 nurses it represents can expect a legislator who is willing to engage and interact with them throughout the Legislative session.

District 29

Lale, Erin (L)

Nevada should remove artificial state-imposed barriers to purchasing health care based in another state so that people can buy affordable health care even with pre-existing conditions and choose the plans they want. In the last session, the Nevada State Assembly raided the budgets of cities, counties, school districts, and water districts to take that money for the general fund. If elected, I will introduce legislation to define fees in Nevada tax law so fees collected for a specific purpose must be used for that purpose or given back. My plan to balance the state budget is to end prohibition of medical marijuana on the basis of the health and safety of society; on the basis of the health and safety of individual patients; spend $500 million less per year on prison. If elected, I will work to support legislation that would reform and improve the Board of Medical Examiners and offer alternatives to doctors who face medical license revocation.I am a first time candidate working hard to become acquainted with NNA's legislative goals. In my daily profession as a Licensed Social Worker, I have the privilege of virtually hospital care setting. I worked with many nurses in an inpatient setting. Often time, the RN and I are problem solving and working together to comfort families when they are emotionally distressed. I trust the nurses I work with implicity, and have the utmost respect for them. I am proud to call many of them my friends. If elected, I believe the NNA, and the 37,000 nurses it represents can expect a legislator who is willing to engage and interact with them throughout the Legislative session.

District 33

Ellison, John [R]

I have been involved in the nursing programs at both the state and local levels. The nurses are the front line defense for the Doctors, they are their eyes and ears and are limited to a direct dialogue with the administration of the hospital. I am hoping to make changes with you involving Nevada. Work and jobs is something the state needs to help to secure the funding with the college system and hospitals. This will have affected the health care of patients, not only in Nevada but throughout the West. With sufficient time for their continuous education programming this will help the nurses, but we need a way to educate the doctors, public and the administrations of the short-fall of more qualified nurses. I have worked on many issues pertaining to nurse and administrative problems with our local assemblyman. I have had an open door policy with our local nurses and have had many informative meetings with them. I cannot make any direct promises, but I will work my hardest for the betterment of all.

District 34

Horne, William (D)

As a citizen legislator, I do my level best to be an active, engaged member of our community. That means being available to groups such as yours to hear your issues and consider your observations on the condition of medical care in Nevada. I have been an advocate for accessible, affordable medical care and I recognize the importance of dedicated, skilled practitioners who work to provide it. I will continue to seek your advice, consider your suggestions, and work for better health care.

District 37

Lupo, Philip [R]

As an elected official I will do everything I can to help your cause that I can, as long as your cause does not become a burden to the tax payers on Nevada. It is my opinion that nurses are the nicest people in the world. I can only imagine what nurses have to deal with every single day. It is not something that everyone can do or want to do.

District 39

Schumann, David (IAP)

My mother was a nurse at Jefferson Hospital in Philadelphia. I support the profession.

District 40

Williamson, Robin (D)

I am Robin Williamson, the Democratic candidate for Assembly District 40, which includes Carson City and parts of Washoe Valley. I am completing my third term in office on the Carson City Board of Supervisors, and I have been a champion of our downtown and economic development efforts. I also served as president of the Nevada Association of Counties and on the Pai, and, as a long time resident of Nevada, have 2 grown daughters. My youngest daughter graduated from the Western Nevada College nursing program four years ago, and is now working in the University of Nevada, Reno School of Medicine Internal Medicine program. I am pleased to announce that I have accepted a practice residency in June and I am working as a faculty practice clinic, La Clinica, in Louisville, Colorado. Medical care and health concerns are very important to me and my constituants and their families. I look forward to working with the Nevada Nurses Association to learn how we can be effective and effective in meeting the needs of our communities.

District 42

Bustamante-Adams, Irene (D)

I have a deep respect for the work done by nurses within our state. In me, you will find someone who is always willing to listen to your concerns and interests. In addition, I will work hard to improve the quality of life for all Nevadans. I understand the level of responsibility you have for this position and it would be an honor to earn your support.

District 8

Frierson, Jason (D)

My name is Jason Frierson and I am running for Nevada State Assembly District 8. I am a 22 year Nevada resident, having committed my entire adult life to public service and community involvement. Even as a child, I recognized the importance of efficient, quality healthcare when my family depended on the emergency room for even basic care. I went on to graduate from UNR with a degree in Health Science, and participated in the AmeriCorps Program. I then worked as an outreach and recruitment officer for the College of Nursing at the University of Nevada, where I recruited students interested in various departments including UNR's College of Nursing. I later became a member of the charter class of the Boyd Law School at UNLV. I've worked in the private sector providing various capacities in the practice of law, spending the past 4 years serving as Nevada's chief Public Defender. I am now running for public office because I believe that with my experience advocating at the past two legislative sessions, my perspective as a practicing attorney, and my personal life experiences, make me especially qualified to contribute to finding solutions to Nevada's serious health care issues.
Meet Nevada's Nurses

Martha Drohobyczer, RN, MS, CNM

Martha Drohobyczer has been a member of ANA since 1980 and of NNA since 1983, but she was not very active in the early years. In 2006, she learned that District 3 had been inactive for four years and resolved to do something about it. "I was never voted in as President; I took it on because no one else would run." The District has grown under her leadership and will hold a general election this fall; she is not seeking another term as President. "District 3 is awake again. People seem to be really interested in pushing nursing forward."

In addition to revitalizing District 3, Martha has accomplished a great deal as President. Recent highlights include:

- A successful Legislative Meet & Greet this year with an excellent turnout. Martha points to the importance of nurses feeling "like they really can accomplish things in terms of changing laws and making the legislators and the public know what nurses really do."
- The first Student Nurse Competition held in spring 2010, a joint project with NNA President, Tracy Singh.

Martha believes that all nurses should belong to their professional organization. "If they can't support with their time, then they should support it financially. NNA is there to help nurses professionally. At various times in our lives it is difficult to serve in an organization. If you can't run for office or serve on a committee right now, being a member still supports NNA. It also benefits you as a nurse."

Martha began her nursing education in the accelerated BSN program at St. Louis University, a Jesuit school, and the oldest school west of the Mississippi. The school celebrated its 80th year of offering a BSN and 50th year of offering an MSN the year Martha graduated. "It was a good place

to go to school. There were nurse researchers as well as nurses that wrote most of the standard nursing textbooks at that time." Martha continued at St. Louis University for her MSN, with the clinical nurse specialist track in psychiatric nursing as her concentration. She says that her first job as a clinical nurse specialist was the "perfect job" but her husband wanted to move to Las Vegas.

In Las Vegas, Martha began working at the Southern Nevada Adult Mental Health Center. She worked as a clinical nurse specialist for one month then took the position as a Director of Nursing. She managed the inpatient facility, the outpatient clinic, and the hospital's oldest and 5 medication clinics. After 5 years in this position, Martha started teaching at UNLV and went into private practice in psychiatry.

In 1992, Martha decided to go into midwifery. At the time the low birth weight and preterm delivery statistics for Nevada were terrible. This was mostly due to the poor birth outcomes for African American women in Las Vegas. She decided to combine psychiatry with midwifery by obtaining a post-master's certificate in Midwifery. Martha was supported in this endeavor by being selected by the University of Nevada School of Medicine, Rural Health Department to be a Community Scholar. As a Community Scholar she was allowed to work in an underserved area in Nevada after graduation. Martha attended the Frontier School of Midwifery and Family Nursing, located in Hyden, Kentucky. This is a very rural very poor area of Appalachia. After graduation she was placed at a federally funded health center in the historically African American area of Las Vegas. "This was a wonderful job. If the clinic had not closed for financial reasons, I would most likely still be working there. It was right in the community that I wanted to deliver services. I worked outpatient at the clinic and did deliveries for the women at University Medical Center in Las Vegas."

After her 2 year commitment to the School of Medicine, she decided to open a women's clinic called Alternatives for Women. "I performed deliveries for 11 years. I even delivered 5 women that were friends that had their babies within several months of each other. They had a second round of babies several years later and I delivered them again. In 2006, I decided to take a break from 24/7 on-call deliveries, now I enjoy my freedom to travel and sleep all night."

Besides her work in NNA District 3, Martha is an active member of the NNA Advanced Practice Nurse Special Practice Group, the Nevada Chapter of the Black Nurses Association, the Nevada Chapter of the American College of Nurses Midwives, The Nevada Chapter of the American Psychiatric Nurses Association and the Filipino Nurses Association. She has served on two Nevada State Board of Nursing committees. In 2004 she received the First Lady's Award (Gemma Guinn) for providing outstanding women's health care in Southern Nevada.

Martha says "the best thing that I ever did was become a nurse. In nursing there are so many career choices and possibilities. I was one of my OB patients considering nursing as a career. She received her BSN from UNLV and this summer moved to Arizona to attend a program for nurse anesthesia. I am always proud to tell people that I am a nurse."

Martha has been married for 35 years. She has 2 adult daughters and one grandson. Martha's contribution to the Nevada Nurses Association and to nurses and patients in Nevada has been tremendous. We gratefully recognize her accomplishments.

Betty Razor, RN, BSN, CWOCN

If you mention NNA in northern Nevada, the first name that occurs to many people is Betty Razor. Serving as District 1 President for 6 years and northern Nevada Legislative Co-Chair since 2006, she has become the face and voice of NNA in northern Nevada.

Betty graduated from a diploma school of nursing 56 years ago and has been a member of ANA since that time. She later completed a BS degree and became certified as a Wound, Ostomy, Continence Nurse in 1998, and has been active in NNA since that time. She

was Communication Coordinator from 2005-2008 and editor of RNFormation from 2005-2008. Betty reports that she came kicking and screaming into the world of computers and internet and is still very uneasy with it. Now, when she has finally become comfortable with email, the electronic world is passing her by again.

As President of NNA, Betty is most proud of the accomplishments in the area of interpersonal relationships. Betty has spent a great deal of time building personal relationships with other nurses and has been a guide and mentor to many. She has improved communication and the interpersonal relationships of nurses in area. She has built networks with other specialty groups like AMSN, ONA, WOCN, and the health department, and always feels that personal relationships among nurses are the most important. She has worked to rebuild the vital relationship between NNA and the hospital, and get an answer. She has built friendships with legislators and good acquaintances with governors and their wives.

Two pieces of legislation that Betty is especially proud of are the enhancement of whistleblower protections for nurses and the first steps to safe staffing legislation. Betty has also worked to help nurses become more involved in the political process. Neena Laxalt first suggested the idea of the legislative meet & greet, but Betty was responsible for initiation of these successful events.

She also reactivated Nurses Day at the Legislature during her time as Legislative Co-Chair. Betty would remind all nurses that Nevada legislators need our help and support to become knowledgeable on health issues.

In addition to her work with NNA, Betty is actively involved in Carson City and northern Nevada. Some of her community activities include:

1. Homeless advocacy in Carson City to provide food and clothing for the children.
2. Founder of a faith community network email networking system
3. Easter Spring into Step shoe drive for kids
4. Supporter for food for thought program
5. Volunteer at the food bank
6. Chair of Health Ministry at church since 2000
7. Watercolor—willing to sell paintings
8. Annual participant in Relay for Life and Race for the Cure
9. Community activist on health issues and support of children and elderly issues

Betty believes that NNA is the most rewarding commitment a nurse can make to nursing as well as a benefit to a nurse's personal life. It provides an opportunity to help and assist other nurses with their problems and to listen and provide interventions. Betty has also made a concerted effort to bring nurses as well as those in long-standing positions. She finds talking to student nurses and seeing them join their organization and become leaders very rewarding, as they are able to help improve their education and their personal lives. In her personal life, it has helped with relationships in her church and with members of her family. She acknowledges that without support of husband, she couldn't do it. He has been open and gracious about her commitments. Betty stresses the need to be able to separate personal and professional life.

Betty has turned over the Legislative Co-Chair responsibilities to Teresa Serratt and plans to step down as District 1 President in 2011. Her service to NNA and the profession will benefit Nevada nurses for years to come.
Peripherally Inserted Central Catheters (PICC) were first introduced in the mid 1970’s and their use has steadily increased since. PICCs are used in all healthcare settings for the intravenous administration of antibiotics, pain medicine, chemotherapy, nutrition, or for the drawing of blood samples. While they serve an important medical purpose, a PICC is not appropriate for all patients. Patients who have elevated serum creatinine and/or decreased eGFR are at risk for developing chronic kidney disease and may need permanent arteriovenous access for future dialysis. For these patients PICCs have the potential to significantly decrease their chance for survival by limiting the sites available for arteriovenous (AV) fistula placement. The AV fistula is the preferred form of vascular access for hemodialysis, delivering superior patency with lower morbidity, hospitalization, and cost compared to synthetic grafts or venous catheters.

Healthcare practitioners should be aware of the potential complications of PICCs and limit the use of PICCs to patients with normal serum creatinine and GFR unless PICC placement is approved by a nephrologist. The nephrologist should decide whether the patient’s abnormal creatinine/GFR are transient or whether the patient has kidney disease and has the potential for need future dialysis. Every patient has only four superficial upper extremity veins, the cephalic and basilic vein in each arm. These two veins join together to form the subclavian vein then the Superior Vena Cava. PICCs are most often inserted in the basilic vein, then advanced so the distal tip of the PICC rests in the Superior Vena Cava. Vein damage anywhere along the length of the catheter, from the insertion site to the Superior Vena Cava, may make the entire extremity useless for future placement of an AV fistula for permanent dialysis access. Vein damage may be caused by many factors and it may take only a short time to render a vein useless for hemodialysis access. Medications infused through the PICC may cause chemical irritation to the venous endothelium or the catheter itself may cause venous irritation. However, the most frequent complications of PICC’s are thrombosis formation and venous stenosis. These complications occur much more often than health care practitioners realize because a patient may be asymptomatic but still develop enough venous stenosis or thrombosis to damage veins and render the entire arm useless for AV fistula placement.

A study conducted by Saad and Vesely found that 23.3% of studied patients developed venous thrombosis after initial PICC placement. This percentage increased to 38% for patients who underwent multiple PICC insertions. Central venous stenosis developed in 4.8% of study participants and 2.7% had central venous occlusion. Even partial impairment of blood flow by thrombosis or stenosis in an extremity will greatly decrease the patient’s chance of receiving a fistula.

The Renal Network recommends that patients with an eGFR of less than 43 mL/min or a serum creatinine level of greater than 2.0 mg/dL should not have a PICC line placed. The Fistula First Organization recommends the use of a small bore central catheter (SBCC) in the internal jugular vessel instead of a PICC for high risk patients since SBCCs can last longer than PICC’s, can be easily replaced, and have fewer complications for the period of time needed.

Patients with kidney disease also need to have their forearm veins protected from venipuncture and IV placement. Only hand veins should be used unless emergency IV access is needed. The following principals should be followed for patients with kidney disease:

- Veins in both arms that could be used for hemodialysis vascular access MUST be preserved.
- Venipuncture or IV placement could damage these veins so they can’t be used for hemodialysis access.
- Subclavian vein catheterization can cause central venous stenosis, which can make it impossible to use that side of the body for hemodialysis access—cutting the patient’s access choices in half.

The first step in preserving peripheral veins of patients who have or are at risk for kidney disease is the early identification of these patients. Some patients may not know they have early kidney disease. Review the patient’s serum creatinine and/or eGFR. If either laboratory result is abnormal consult a nephrologist before placing the PICC. This simple step may extend your patient’s life. PICC’s are not appropriate for all patients.

This material was prepared by HealthInsight, the Medicare Quality Improvement Organization for Nevada and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

### Endnotes

5. Liz is currently a Project Coordinator for HealthInsight, the Medicare Quality Improvement Organization for the state of Nevada. As the hospital liaison, Liz works with acute care facilities to ensure that quality improvement projects are developed and implemented within the context of the Centers for Medicare & Medicaid Services contract. Liz also provides educational support and research on evidenced based best practices to facilities to assist in the improvement of CMS quality measures.
6. Liz has over 28 years experience as a Registered Nurse including Emergency, Critical Care, Staff Education and Quality Improvement. Liz is currently working toward her Master’s Degree in Nursing.

The current epidemic of pertussis (whooping cough) in the US, the first since 1958, is likely due to the increasingly vocal opposition by media stars and internet “experts” to childhood vaccination. It has been estimated that 70% of media coverage of the possible link between the MMR vaccine and autism, for example, has noted a possible link while only 37% has advised that the vaccine is safe. As of June 15, 2010 there have been 910 confirmed cases of pertussis in California with another 600 cases under investigation (ABC News). There have been numerous other disease outbreaks in the U.S. related to refusals of immunization. With measles, for example, in 2008 there were five measles outbreaks in the country, and investigation showed that only one of the infected persons had been vaccinated.

Nevada permits immunizations for school children to be refused due only to documented religious beliefs or medical conditions (NRS 392.435), but many other states, including California, allow exceptions for philosophical or personal reasons. The numbers of states without nonreligious, nonmedical exemptions is increasing the chances of further public health problems.

Interestingly, studies of unvaccinated children show that they were more likely to be white, male, belong to higher income households, to have married mothers with college educations, and to live with four or more other children (Smith, Chu, & Barker, 2004). A primary reason for vaccine refusal continues to be concerns over vaccine safety. The concern over vaccines causing autism has persisted in the face of overwhelming evidence to the contrary, for example. Nurses, and especially nurse practitioners, must be prepared to deal with this problem. They need to be ready and able to counsel parents on the necessity and safety of following recommended childhood vaccination schedules. This is necessary not only for the safety of the individual child but also for the public as a whole.

### Nevada RN Refusal Form

**HealthInsight Project Coordinator**

Liz Gorka RN, BSN, CCRN

### Touro University Nevada

Liz has over 28 years experience as a Registered Nurse including Emergency, Critical Care, Staff Education and Quality Improvement. Liz is currently working toward her Master’s Degree in Nursing.
Protecting Patient Information

John Malek, PhD, MSN, FNP-C

The profession of nursing is most notably held to the highest ethical and moral standards. With the introduction of electronic medical records and information technology the basics of protecting patient information should not be overshadowed by the need to improve our information systems. Nurses have access to extensive medical and personal information of patients as part of their overall plan to meet their needs with the highest quality. Unfortunately, there are times when this information is obtained by others either purposefully or by accident. Regardless of the situation, we must be ever vigilant to assure this information is protected. Whether the patient is a friend, co-worker, acquaintance or complete stranger, confidentiality is crucial.

Patient privacy and security rules are enforced by the Office for Civil Rights. The security and protection of health information are national standards set forth in the Privacy and Security Rules. These rules apply to covered entities such as individuals, organizations and agencies that must comply with requirements to protect the privacy and security of health information regardless of how this information is collected. While it is necessary to share information about patients, a major goal of the Privacy Rule is to protect the public’s health and well-being. The enforcement process for protecting patient information involves investigation of complaints, conducting compliance reviews and performing education. Fines for violating the privacy of patient information range from one-hundred dollars per offense to a maximum of twenty-five thousand dollars per year on any person who violates a provision. Depending on the circumstances surrounding a violation, penalties can reach hundreds of thousands of dollars and include imprisonment of up to ten years.

Provision three of the ANA Guide to the Code of Ethics for Nurses has been expanded to include all patients, even those with diminished capacity, who encounter the nurse and need assistance to protect their universal health needs. According to the provision, “Confidentiality is a term that refers to sharing protected health information only with those who are authorized by the patient.” The issue of confidentiality is highly complex. Medical information passes through many hands. This information is seen, discussed and heard.

The most significant contribution nurses can make to patients is through education and advising. Patients should always be informed of where their data will be stored, who will have access to it, and with whom it will be shared. Remember that loose lips sink ships! Unless the discussion of patient information will be utilized to assess, diagnose, implement treatment or evaluate care and patient outcomes, there is no justification to discuss protected information in a casual, non-professional manner such as gossip, discussing patient information in public places or with other patients unless explicitly authorized by the individual. Sometimes, what you know or what you say can be harmful to your patient, self or organization.

References
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html;


Consequences for the nurse (Glender-Russo, 2009). Roberts (2003) cited past research that has explored the implications of oppressed group behaviors on the nursing profession. The research has shown that powerless groups have difficulty taking control of their destiny due to internalized beliefs regarding their own inferiority. This in turn leads to a cycle of self hatred and the inability to unite to challenge the inequalities of power that have lead to oppression (Roberts, 2000). Roberts (2003) proposed, as a solution to oppression, a model for identity development for nursing based upon models of other oppressed groups. One aspect of developing positive identity was advanced through organizational structure that promoted autonomy. Matheson (2007) concluded that empowerment is more important than ever in light of the nursing shortage and that autonomy of the nursing profession can only come from within the profession through introspection, education, and enlightenment. Daiski (2004) solicited suggestions for change from Aiken, 2002; ANCC, 2005). Nursing leaders owe it to the staff, their facilities, and patients to begin the process to ensure empowerment and autonomy within the work environment such as shared governance and peer process. Olender-Russo (2009) speaks of developing a culture of regard as an antidote to oppression. The process of oppressive group behaviors on the implications of oppressed group behaviors on the nursing profession. The research has shown that powerless groups have difficulty taking control of their destiny due to internalized beliefs regarding their own inferiority. This in turn leads to a cycle of self hatred and the inability to unite to challenge the inequalities of power that have lead to oppression (Roberts, 2000). Roberts (2003) proposed, as a solution to oppression, a model for identity development for nursing based upon models of other oppressed groups. One aspect of developing positive identity was advanced through organizational structure that promoted autonomy. Matheson (2007) concluded that empowerment is more important than ever in light of the nursing shortage and that autonomy of the nursing profession can only come from within the profession through introspection, education, and enlightenment. Daiski (2004) solicited suggestions for change from nurses, their work; awareness of workplace issues; education emphasizing mutual support and the nature of oppression; and involvement in decision-making processes. Glender-Russo (2009) speaks of developing a culture of regard as an antidote to oppression. The culture of regard consists of three elements: recognition of nursing, empowering nursing, and facilitating goal attainment.

The above recommendations parallel the formation of organizational models that promote nurse empowerment and autonomy within the work environment such as shared governance and peer review. These models are typically used within facilities to empower nurses in their practice with the result of increased job satisfaction, decreased sick time utilization, and improved retention of nursing staff. Aiken, 2002; ANCC, 2005). Nursing leaders owe it to the staff, their facilities, and patients to begin the process of nurse empowerment and leave the history of oppression where it belongs—in the past.

For comments, please contact Dr. Brann at mary.brann@tun.touro.edu.

References


Interested in learning more about Nevada’s state government? The State of Nevada maintains a website detailing activities of the executive, legislative, and judicial branches. “Nevada state government” lists links for communicating with elected federal and state officials. “Legislature” includes the Nevada law library, portrait database, tracking, and 2009 session information. “Supreme court” connects readers to legislative calendars and tracking reports.

Please visit the State of Nevada website at www.nv.gov/.

The Nevada Legislature aims to educate and inform Nevada residents by offering a wide array of topics. “General info” presents a directory of state and local government, legislator and committee information, and a brief overview of the legislative process. “Interim info” introduces the committees and studies that continue beyond the legislative session. “Session info” lists the bill draft requests under consideration during the legislative session. Please note that these are just a few of the topics available. In addition, readers are invited to share opinions and offer suggestions on controversial issues. This is a perfect opportunity to make your voice heard, and to help in shaping the future of Nevada.

Please visit the Nevada Legislature at www.leg.state.nv.us/.
Living with a Latex Allergy - Part 2

By Margaret Konieczny, RN, MSN

I want to thank the readers for their comments and questions regarding my first article. One of the most common comment and misconception is that latex allergy is only a contact dermatitis. It is not. There are three classifications: the first is Irritant Contact Dermatitis, which is localized, and has a red rash type of reaction to direct contact with the skin. The second, Allergic Contact Dermatitis, is also localized, and cell mediated, and is known as Type IV and the third is Latex Allergy Type I, a systemic and IgE mediated response, a true allergy. However, there is a relationship between the initial type, irritant contact dermatitis, and the development of the true latex allergy type I. In my book I will go into more detail regarding cell mediated and IgE mediated responses.

In Irritant Contact Dermatitis skin is damaged by frequent washing and wearing of latex gloves and may become reddened, dry, and itchy. This does not involve the immune system and is not an "allergy". However the damaged skin increases the possibility of the absorption of latex proteins which increases the likelihood of progressing to the latex protein allergy.

Type IV allergic Contact Dermatitis is a cell mediated reaction to the chemicals used in the manufacturing process of latex. This is a delayed hypersensitivity reaction. Type I is the true latex allergy and is an immediate response to latex exposure and with each exposure can increase in severity, even to anaphylaxis. It is possible to have both a Type IV and Type I (Pacific Northwest Foundation 2005).

I went through these stages from damaged skin and contact dermatitis, to Type IV and Type I. Currently my reaction starts within 1 to 2 hours of exposure. It starts with blotchy facial redness, tightness, swelling, itching, and burning of the facial skin and neck, and watery itchy eyes. Within the next 24 hours the itching will spread to my neck and shoulders with uticaria and shortness of breath. Once the reaction starts there is no stopping it. It has to run its course.

From 1992 to 1998 there was a slow persistent progression of symptoms. I will never forget how I felt and how I looked on the day my employer finally removed me from hospital duty and transferred me to home health nursing, around the first of May, 1998 and I bought a new bathing suit. One hour after wearing the bathing suit in a pool I began to itch. My face reddened and became swollen and itchy. Eyes watered. When I presented myself to the allergist he finally acknowledged that this could be due to latex (spandex) in the bathing suit. However, he wrote a note for me to return to work, to avoid latex and to wear vinyl gloves.

After my return, to work on April 23, 1998 my symptoms again reappeared this time with increased intensity. I had total body swelling, shortness of breath, and total body rash, itching, watery eyes. My knees were so swollen I could not bend them. I had lesions on my upper body, shoulders, neck, thighs and behind my knees. These symptoms had returned quickly. The newest symptom was the SOB on exertion. I was so devastated and frustrated that I felt I was not being treated correctly.

I researched the internet for more information on latex allergies and found a latex allergy support group called ALERT. I asked if they knew of any physicians in my area, Reno to Sacramento that were knowledgeable about latex allergies. They were very helpful and gave me a list of physicians and one of the allergists on the list was Dr. John Saylor! Help at last! He knew and he understood. On May 1st 1998 he diagnosed me with a latex allergy Type I and he wrote that I was unable to return to work until a latex safe environment was provided… “Occupational injury report to follow”. My life changed almost immediately. With the proper diagnosis and work release, the hospital administration moved me to the Home Health Department and out of the hospital entirely.

For more information contact: ALERT web site, www.latexallergyresources.org

Pacific Northwest Foundation web site, www.pnf.org

In future issues:
Part 3 Journey through Worker’s Compensation, and Employer Accommodations
Part 4 Life Today

Reference

This is part two of a four part series by Margaret Konieczny, RN, MSN recounting her personal experience with her latex allergy diagnosis. Ms. Konieczny is currently writing a book recounting her experience in more detail, including a history of nursing leading up to the use of latex gloves. She is also including personal stories of other health care professionals diagnosed with a latex allergy. Check out her Web Site KanKpublishing.com for publishing dates.

We would love to hear your thoughts and ideas. Please share them with us in the comments section. Check out our website at www.pacificnorthwestfoundation.org to find out more about this fascinating topic.

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Written by: Margaret Konieczny, RN, MSN

This is a personal story of how I experienced latex allergy and how I fought to have my diagnosis accepted. I hope you find it interesting and informative. Please check our website at www.pacificnorthwestfoundation.org to learn more about this fascinating topic.

Thank you for reading my story.
Evidence-based practice has been emphasized in the nursing literature for more than a decade, but is it present in practice? Probably the best and most current definition of evidence-based practice is that of Straus, Richardson, Glaziou, and Haynes (2005) who described it as “Integration of best research evidence with clinical expertise and patient values and circumstances.” One question which arises frequently in daily nursing practice concerns the necessity of performing aspiration prior to injection of intramuscular medications. Does that technique follow evidence-based practice?

A search of the literature on intramuscular injection techniques demonstrates that aspiration is routinely recommended. In the Journal of Advanced Nursing, for example, Rodger and King (2000) developed guidelines based on a review of the literature and stated in their injection guidelines that it is necessary to “Aspirate for blood—if present, discard and repeat the whole procedure” (p. 580). They stated that “The literature based practice? One example of performing nursing skills because “that’s the way we’ve always done it” instead of using evidence-based practice. Perhaps it is an area in which someone could do some clinical research.

A questionnaire was used to assess knowledge. Johnson and Crawford (2008) suggest that a conjecture by a physician in the 1930’s that one could mistakenly enter a vein when administering intramuscular penicillin was the source of the practice although no research evidence has been developed to support that conjecture. It certainly seems that this is a sensible precaution, but where is the evidence? This seems to be but one example of performing nursing skills because “that’s the way we’ve always done it” instead of using evidence-based practice. Perhaps it is an area in which someone could do some clinical research.

Evidence-based medicine: How to practice and teach EBM (3rd ed.). By Shirley Jordan-Seay, Ph.D., OCN, CTR TUI University 2010

An internet-based study was conducted to evaluate registered nurses’ knowledge and recognition of assessment parameters for displaced tracheostomy tubes in patients with obstructed upper airways. Furthermore, the study sought to determine whether there were any factors that were predictors of nurses’ knowledge levels. There were 221 nurses who participated in the study that queried their knowledge related to recognition and intervention for patients with displaced tracheostomy tubes in obstructed and unobstructed upper airways. A questionnaire was used to assess knowledge.

The study results indicated that educational level is independent of nurses’ knowledge of tracheostomy management for a displaced tracheostomy tube in tracheostomy patients with an unobstructed upper airway, which would cause death in the patient. A significant knowledge gap was noted related to identification and appropriate management of displaced tracheostomy tubes or accidental decannulation in patients with obstructed and obstructed upper airways. Eighty-three percent of nurses did not recognize that, in the patient with an unobstructed upper airway, improved voice signals a need to assess for tracheotomy tube displacement.

The study also found that, in term of practice settings, nurses who were employed in an inpatient practice were a significant predictor for higher scores for knowledge of unobstructed airborne when compared to nurses who practiced in other practice settings (B = .693, p = .016). On the parameters of practice setting for overall knowledge of obstructed and unobstructed airways, nurses who practiced in an inpatient setting was a significant predictor of overall knowledge scores when compared to nurses who practiced in a nursing home setting (B = –.016, p = .044). Experience providing care to tracheostomy patients was the strongest predictor of overall knowledge scores (B = .181, p = .017). Failure to, in a timely fashion, detect a tracheostomy tube displacement into the subcutaneous tissues of a patient who has a tracheotomy inserted as a protective measure in anticipation of a future upper airway obstruction and intervene may result in increased patient morbidity and mortality. Further, failure of the nurse to recognize that there is a difference in how to provide respiratory support and patient management for an accidental decannulation in a tracheostomy patient with an unobstructed versus an obstructed airway may lead to patient death due to improper action on the part of the nurse. In addition, the nursing literature may inadvertently inform nurses to perform actions that may lead to patient death because many articles fail to clearly distinguish between assisting ventilation in the tracheostomy patient with an unobstructed airway and appropriate options for the patient with an obstructed upper airway.

References


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Make check payable to: Nevada Nurses Association. Send to: Nevada Nurses Association, Conference Committee, PO. Box 34600, Reno NV 89553
In the past twenty years, EBP has emerged as a more global movement. This movement includes more than research utilization and has developed many more relevant EBP models that promote scientific and other evidence sources to improve the quality of care (Estabrooks, 1999; Rosswurm & Larrabee, 1999; Stetter, 2001, 2003; Titter et al., 1994; Stevens 2004). In the new millennium, EBP is an umbrella term for many sources of evidence, including, but not limited to systematic reviews, consensus recommendations by experts, and clinical guidelines (Roberts, 1998; Roife, 1999; Stetter et al., 1998; Jennings & Loan, 2001; Stevens, 2002, 2004, 2005). Among the more fine-grained EBP models are the ACE Star Model of Knowledge Transformation® (Stevens, 2004) and the Johns Hopkins Nursing EBP Model and Guidelines (Newhouse et al., 2007).

The ACE Star Model of Knowledge Transformation (Figure 2) organizes both old and new concepts of improving care and provides a framework to categorize EBP processes and approaches. This conceptual model is developed with an understanding of the cycles, nature, and characteristics of knowledge that are utilized in various aspects of EBP. It depicts the relationships between various stages of knowledge transformation, as newly discovered knowledge is moved into practice. According to the ACE Star Model, EBP is the study of transforming knowledge produced through original studies into a basis for clinical decision-making (Stevens, 2004, 2005). Table 1, describes the underlying premises of knowledge transformation.

The model is configured as a simple 5-point star; the model points explain that knowledge is transformed at five major stages, from original research, through the stages of evidence summary, translation, implementation (See Figure 2 and Table 2).

Table 1: Underlying Premises of Knowledge Transformation (Stevens, 2004, 2005)

<table>
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<tr>
<th>Stage</th>
<th>Description</th>
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<td>1. Knowledge transformation is necessary before research results are usable in clinical decision making.</td>
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<td>2. Knowledge derives from a variety of sources. In healthcare, sources of knowledge include research evidence, experience, authority, trial and error, and theoretical principles.</td>
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<td>3. The most stable and generalizable knowledge is discovered through systematic processes, namely, the research process.</td>
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<td>4. Evidence can be classified into a hierarchy of strength of evidence. Relative strength of evidence is largely dependent on the rigor of the scientific design and the research process.</td>
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<td>5. Knowledge exists in a variety of forms. As research evidence is converted into practice recommendations and integration into practice, the aim of translation is to provide a useful and relevant package of recommended evidence to clinicians and clients (CPGs) and may be represented or embedded in care standards, clinical pathways, guidelines, and algorithms. CPGs are tools to support evidence-based decision-making for the clinician, organization, and client.</td>
<td></td>
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<tr>
<td>6. The form (‘package’) in which knowledge exists can be referenced to its use; in the case of EBP, the ultimate application is use in healthcare.</td>
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<td>7. The form of knowledge determines its usability in clinical decision making. For example, research results from a primary investigation are less useful than an evidence-based clinical practice guideline.</td>
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<td>8. Knowledge is transformed through the following processes: summation into a single statement about the state of the science, translation of the state of the science into clinical recommendations, with addition of clinical expertise, application of theoretical principles, and client preferences, integration of recommendations through organizational and individual actions, evaluation of impact of actions on targeted outcomes.</td>
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Table 2: Explanation of the ACE Model’s ‘Star Points’

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<th>Stage</th>
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<td>1. Discovery: This is a knowledge generating stage. In this stage, new knowledge is discovered through the traditional research methodologies and scientific inquiry. Research results are generated through the conduct of a single study. It may be a primary research study and research designs range from descriptive to correlational to causal; and from randomized control trials to qualitative. This stage builds the corpus of research about a clinical action.</td>
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<td>2. Evidence Summary: Evidence summary is the first unique step in EBP—the task is to synthesize the corpus of research knowledge into a single, meaningful statement of the state of the science. The most advanced EBP models date to those used to develop evidence summaries (i.e., evidence synthesis, systematic reviews, e.g., the systematic review methods outlined in the Cochrane Handbook) from randomized control trials. Some evidence summaries employ more rigorous methods than others, yielding more credible and reproducible results. The rigorous evidence summary stage distinguishes EBP from the old paradigm of research utilization. Largely due to the work of the Cochrane Collaboration, rigorous methods for systematic reviews have been greatly advanced, using meta-analytic techniques and developing other statistical summary strategies.</td>
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<td>3. Translation: The transformation of evidence summaries into actual practice requires two stages: translation of evidence into practice recommendations and integration into practice. The aim of translation is to provide a useful and relevant package of recommended evidence to clinicians and clients in a form that suits the time, cost, and care standard. Recommendations may be represented or embedded in care standards, clinical pathways, guidelines, and algorithms. Recommendations are tools to support evidence-based decision-making for the clinician, organization, and client.</td>
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<td>4. Integration: Integration is perhaps the most familiar stage in healthcare because of society’s long-standing expectation that healthcare be based on most current knowledge, thus, requiring implementation of innovations. This stage involves changing both individual and organizational practices through formal and informal channels. Major aspects addressed in this stage are factors that affect individual organizational and societal transformation of innovation and factors that affect integration of the change into sustainable systems.</td>
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<td>5. Evaluation: The final stage in knowledge transformation is evaluation. In EBP, a broad array of endpoints and outcomes are evaluated. This includes evaluation of the impact of EBP on patient health outcomes, provider and patient satisfaction, efficacy, efficiency, economic analysis, and health status impact. As new knowledge is transformed through the five stages, the final outcome is evidence-based quality improvement of health care.</td>
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