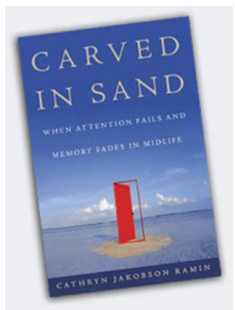
The Newsletter of the American Nurses Association–Maine SPRING 2008

Journal Highlights



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President's Message

Thoughts about nursing and healthcare reform

Sue Henderson
President

In March, I was privileged to be interviewed by Jennifer Rooks of the Maine Public Broadcasting Network. "Maine Watch" for a program on nursing issues. Also interviewed was Cecile Martin from Maine State Nurses Association. Laura Schneck, a reporter from MPBN, did the field interviews. All in all, nursing was portrayed in a very positive light. I was delighted at how the two nurses from Farmington Memorial who opened the program demonstrated and spoke of the nurse's commitment to caring and I was pleased that the public could see this.

Pam Ernest, as nursing director, spoke of the multiple complexities within which nurses function. Cecile delineated the need for holistic care and the desire of nurses to provide quality care. Issues of the nursing shortage and the importance of a positive work environment were presented. The discussion then moved to access to care and Cecile and I both shared concerns for those without adequate access to the healthcare system for timely, appropriate, quality care. (If you go to the MPBN Web site you probably can still see the video online.) I think that the program presented the message that nurses care about patients and that nurses do make a difference every day and that the nursing profession has a huge potential to contribute to the health and well-being of our society.

We, as nurses live the issues of healthcare reform every day.

ANA's Health System Reform Agenda was published in February 2008. It presents the issues of access, cost, quality of care and the nursing work force in a clear, concise and patient-focused format. In healthcare reform, a patient-focused format is the gift of the nursing profession. ANA, as nursing's professional organization, is inclusive of all nurses. Its voice furthers its mission of improving the health of the public and advancing the profession of nursing to improve patient outcomes. ANA's work is built on a foundation of its mission, a social policy statement and a code of ethics. *ANA's Health System Reform Agenda, 2008* is based on this foundation.

The underlying premise of the Agenda is that **"ANA remains committed to the principle that health care is a human right and that all persons are entitled to ready access to affordable, high-quality healthcare services"** (ANA, 2008, page 5). Because ANA believes health care is a basic human right, its supports "a restructured healthcare

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Developing Nursing Core Competencies

by Diane E. Scott, RN, MSN

Developing meaningful competency requirements for registered nurses continues to confound the nursing profession. The challenge it presents for healthcare regulators is learning how to objectively measure competencies across various settings, specialties, years of experience and geographic regions. According to Oppewal et al. (2006), core competencies have been developed in different specialty areas, but even nurses' awareness and implementation of such standards vary. The National Council of State Boards of Nursing (NCSBN) has worked, through their committees of Research and Practice, Regulation, and Education, to develop a program to transition graduate nurses into the profession; this program has been a culmination of research and defines the needs of new nurses. Spector and Li (2007) discuss this ongoing research that is being completed to assess the design of this program.

At the Center for American Nurses LEAD Summit 2008, Dr. Mary Ann Alexander, Chief Officer of Nursing Regulation for the NCSBN, will present current research and findings about past, present and future issues related to continued nursing competence. Dr. Alexander also serves on the Steering Committee for the National Coordinating Council for Medication Error Reporting and Prevention, which promotes open communication between healthcare providers, reporting of errors and improvement and dissemination of strategies to maximize safe medication use.

In a recent interview with Dr. Alexander, the Center discussed her role and previewed what attendees at LEAD Summit 2008 will learn about nursing core competencies.

Center: Could you provide an overview of your role at the NCSBN?

Dr. Alexander: NCSBN is a nonprofit organization whose mission is to provide leadership to advance regulatory excellence. The organization serves 59 state boards of nursing from across the United States and its

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President's Message

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system that ensures universal access to a standard package of essential healthcare services for all citizens and residents" (ANA, 2008, page 5). The Agenda defines access not only as affordable care, but care that is available in terms of place and time of delivery and acceptable in terms of respect shown to patients and demonstrated cultural competence.

The Agenda draws upon the work of the Institute of Medicine's (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. Quality care is defined as safe, effective, patient-centered, timely, efficient, and equitable.

In terms of cost of care, ANA recommends a shift in the orientation of our healthcare system from illness care to prevention and wellness interventions. It is recommended that if healthcare spending is viewed as a pyramid, the base consists of primary care, the next level, secondary care, and the smallest and third level, tertiary care.

While recognizing the economic complexity of health care, **"ANA supports a single-payer mechanism as the most desirable option for financing a reformed healthcare system"** (ANA, 2008, page 9). Moreover, it is critical that the view of nursing shift from that of a cost to the healthcare system to that of an economic benefit based on the ability of nurses to prevent complications and adverse events and to provide quality care.

In addition to the concepts of quality, cost and access, the 2008 Agenda has included the nursing work force as a fourth major variable for consideration. The supply, education, distribution and utilization of the nursing work force are issues that need to be addressed. "Maintaining a stable registered nurse work force will require the political, legislative and policy focus to implement and maintain these strategies over the long term" (ANA, 2008, page 11). Strategies to maintain a positive work environment that fosters recruitment and retention are deemed essential.

Title VIII programs under the Public Health Service Act, if fully funded, can be used to support many initiatives, such as hospitals on their magnet journeys. ANA supports limiting nursing work hours to promote safety and reduce errors. ANA also states it is essential that nurses be included in the development of safe staffing patterns. The Agenda stresses the need for financial support for nursing education whether at the entry level or for RN-BSN programs or advanced degrees that would increase nursing faculty.

Finally, the Agenda recommends that barriers be removed so that reimbursement policies encourage the **"broader utilization of all types of providers"** (ANA, 2008, page 13).

"Bold action is called for to create a healthcare system that is responsive to the needs of consumers and provides equal access to safe, high-quality care for every citizen and resident in a cost-effective manner… Nursing's plan for reform continues to be a viable approach to solving the nation's healthcare crises (ANA, 2008, page 15).

Quality, cost, access and nursing work force issues are not abstract concepts to practicing nurses. As ANA-Maine President, I have been doing several things. In December, I was invited, along with many others, to testify before the Health Care Advisory Council, about a report on "cost drivers" in our healthcare system. Nursing was identified as a cost driver. One of the points of my testimony was that it is erroneous to consider nursing as a cost driver; nursing should be viewed more as a cost saver. I also noted that it was likely to be cost-effective to provide services for patients so that they are not compelled to use the emergency room for care and brought the executive Summary of ANA's 2005 Agenda for Health Care Reform to committee members. I have written a letter requesting that ANA-Maine have a seat on a committee of the Maine Quality Forum. We have not yet received a response.

This morning, in response to an e-mail from ANA, I called Sen. Olympia Snowe's office and asked that she sign a letter supporting funding for nursing education through Title VIII. An e-mail was sent to ANA-Maine members, asking them to do so also.

And finally, a couple of weeks ago on "Maine Watch," I spoke of the importance of positive work environments and financial support for nursing education as ways to address the nursing shortage. So these are some of the things I have been doing.

I hope that you will go the ANA Web site and not only read the 2008 Agenda but get really excited about it.

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Developing Nursing Core . . .

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territories. There are two divisions in our organization: Regulatory Programs and Business Operations. I oversee the Department of Regulatory Programs. Within this division are NCSBN's programs in nursing education, practice and credentialing, research, and licensure and discipline. Numerous national meetings, projects, policies and initiatives emerge from this department in response to the regulatory needs and trends of nursing in the United States and territories.

As the Chief Officer of Nursing Regulation, my first and foremost responsibility is to ensure the development of quality programs and the dissemination of timely and useful information, resources and services to meet the needs of our member boards. I am responsible for ensuring that all of our programs, projects, policies and initiatives fulfill the mission of the organization. The staff and I constantly work to evaluate nursing trends, examine opportunities and address regulatory challenges.

I, along with our CEO, Kathy Apple, and the directors within Regulatory Programs, share the responsibility of representing NCSBN at national meetings. I sit on national advisory panels, attend policy meetings and give presentations at national/international conferences. Along with other members of our leadership team, I periodically visit the state boards to assess their needs and update them on our projects and activities. We share the responsibility for building and maintaining relationships with our member boards as well as with nursing leadership organizations and other stakeholders.

I am also responsible for the direct development of several initiatives and projects. I oversee our Center for Regulatory Excellence Grant Program, which will award 2.5 million dollars in grants this year; I am exploring research related to patient safety and examining potential regulatory interventions; and I am currently the lead staff for our continuing competence initiative.

Center: In your research, have you found that there is agreement on competency requirements for registered nurses?

Dr. Alexander: Yes. NCSBN conducted a post-entry RN practice analysis, which was the first of its kind to scientifically determine whether core competencies existed across all areas of nursing. Scientific data emerged from a survey administered to a random sampling of nurses in the profession. Over 4,700 RNs participated. The geographic distribution, gender, ethnicity and work settings of the survey respondents in this study were extremely comparable to the sample of nurses described in the Health Resources and Services Administration's (HRSA) study, *The Registered Nurse Population: National Sample Survey of Registered Nurses* (HRSA 2004). The results from our practice analysis determined core competencies for RNs existed regardless of nursing specialty or practice setting. For example, the competencies that were identified according to frequency and importance most often by survey participants included: patient-centered care, working with the interdisciplinary team and communication. These were not only identified by nurses across the country that participated in our study as being essential for competent practice, but they were also identified by the Institute of Medicine (IOM) and the Quality and Safety Education for Nurses (QSEN) faculty. In fact, all of the competencies outlined by the IOM and QSEN were identified in our practice analysis.

In addition, while the purpose of our study was to identify the competencies that are essential for nurses in the United States, it is interesting to note that, when we presented the post-entry practice analysis at a conference in Toronto with regulators from around the world in attendance, individuals commented that what we had identified were universal competencies that should be core to nursing practice around the world.

Collaboration of educators, practitioners and regulators to advance nursing and improve outcomes for patients. NCSBN's vision is to build regulatory expertise worldwide. It is my vision that our regulatory programs will be a center for knowledge, not only for regulators in the United States, but on a global scale as well.

Center: What is your vision for the future related to the regulation of nursing practice?

Dr. Alexander: Together with leaders from across all areas of nursing, we will continue to develop ways to ensure competency of nurses and safer systems for patient care. There will be even more collaboration of educators, practitioners and regulators to advance nursing and improve outcomes for patients. NCSBN's vision is to build regulatory expertise worldwide. It is my vision that our regulatory programs will be a center for knowledge, not only for regulators in the United States, but on a global scale as well.

Center: What will nurses attending your session at the LEAD Summit learn?

Dr. Alexander: Nurses will learn past, present and future issues related to continued competence. The presentation will include:

1) A discussion about the significance of continued competence, its purpose and why this issue has come to the forefront of nursing
2) An examination of the history of the continued competence movement from a national and global perspective
3) The current status of continued competence in nursing across the United States
4) The future of continued competence, including data for and against various methodologies
5) Research done by NCSBN identifying RN core competencies

For more information about the LEAD Summit, please visit www.leadsummit2008.org.

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Nurses' Committee Provides Grants and Support for Good Ideas

The Center for American Nurses' Growth, Innovation and Advocacy (GIA) Committee

by Jacqueline Fournier, APRN, BC

I am a member of the Center for American Nurses' Growth, Innovation and Advocacy (GIA) Committee. And here you thought it was some type of bacteria strain! I am fortunate to represent ANA-Maine nurses as a member of this committee. GIA Committee membership is made up of various professional nurses from the U.S. We hail from Virginia, Florida, Maryland, Tennessee, South Carolina and, yes, the great state of Maine. You may find yourself asking the obvious questions I did when I first learned about this committee…

What Does the GIA Committee Do Anyway?

Well, the GIA Committee does yearly reviews of grant applications submitted from the Center's member state nurses associations for ideas that are creative *(innovative)* so that we may grow stronger in our state *(growth)* and stand together as nurses in any workplace setting *(advocacy)*. The group commitment is two years and includes this volunteer activity:

1. Meet by phone four times a year and face-to-face one day in Silver Spring, Maryland, where review and approvals occur for well-thought-out and well-developed grant application.
2. Carefully consider in the grant applications how programs to advance workplace advocacy can sustain themselves after the monetary award from the Center has been given.
3. Look at how the grant writers actually considered the issues that are pressing and need action. The nature of the review really tries to look at key ways we as nurses can grow strong and effective in what we do best—caring. Here is a smattering of very focused issues that are examined:
   - Improve the work conditions for nurses
   - Help develop our present and future nurse leaders
   - Keep nurse strong and want to remain in the profession
   - Create new ways of approaching today's issues
4. We then call the applicants/writers and get clarification on their applications if we need to. As a rule there are always questions and it is the best practice not to second-guess the writer but rather ask the questions directly.
5. We then make our recommendations for monetary awards to the Board of the Center.
6. And if you think the work is then done, you are wrong! The work is ongoing since we have to see what progress previous grant awardees have made.

What Can the GIA Committee Do for RNs in Maine?

We can be creative and proactive. We, in Maine, can consider a project that can increase nursing activism, improve a nurse's world, and build our leadership in today's healthcare domain. We can consider applying for a GIA grant as seed money for a project right here in our own back yard. We can share previous program successes from other states and incorporate them right here. We can share our own successes with those same nursing partners in other states. Can't you just feel the energy and possibilities for our state? I think the idea of working with other state nurses associations is key to keeping us strong and being able to make the changes in nursing that we need.

What Is Next?

Any nurses out there with great ideas for making Maine nurses strong? Other than becoming an active member of ANA-Maine, of course! Share your ideas with the ANA-Maine Board members (listed on page 2 of this ANA-Maine Journal).

Also, I can be contacted as your representative on the GIA Committee. My number is (207) 621-3672. Please share your thoughts with us. Thanks for letting me represent Maine on this national committee of the Center for American Nurses!

Student Corner

Implications of Gender on the Nursing Profession

by Monique Crawford

As a nursing major at St. Joseph's College, I can see the issue of gender by simply glancing into any nursing class. There are significantly more females in the nursing department than there are males, which is representative of the nursing profession as well. In 2000, approximately 94.6 percent of nurses in the U.S. were women (Chitty, K., 2005). This statistic alone implies a multitude of issues concerning gender in the nursing profession. Although male nurses deal with discrimination, women, who make up the majority of the nursing field, are also faced with discrimination.

With nearly 95 percent of nurses in the U.S. being women, it appears obvious that being a woman will certainly help me as I move into my professional career. I think that this overwhelming majority really helps women feel as though they are on a level playing field when applying and interviewing for jobs. I think this is true even in the classroom setting in nursing classes at college, where the overwhelming majority of students are women. In addition to feelings of equality and everyone being on the same level, I also feel as though not having very many males in nursing classes helps women academically. I believe it helps to relieve the pressure of looking good in front of male students so females can concentrate solely on academics.

One piece of information I found particularly interesting was that Florence Nightingale, who played a major role in the history of modern nursing, also played a major role in excluding men from the nursing profession by asserting that nursing was a female discipline. She worked hard to establish nursing as a worthy career for "respectable women" and largely ignored the historical contributions of men. Nightingale saw the male role as confined strictly to supplying physical strength, in tasks such as lifting or moving the patients (Chitty, K., 2005). Throughout history, men have faced the same type of gender inequalities and discrimination in nursing that women have struggled to overcome in other professions. During the Industrial Revolution, for example, nursing was not considered an "accepted" profession for men. The accepted professional areas for men included science, technology, and business. Based on this standard implemented by society, men chose careers in medicine, while women chose nursing careers (Chitty, K., 2005). The U.S. government also contributed to the discrimination of men in the nursing profession, when Congress created the Army Nurse Corps in 1901, for female nurses only. The Navy Nurses Corps came later, in 1908, and was also restricted to female nurses. It was not until after World War II with the passing of the GI Bill that the number of male nursing students increased due to the increased funding for education (Chitty, K., 2005).

Although men have been discriminated against in the past and are less numerous in the nursing profession than women, statistics show that gender does in fact hinder women in the predominantly female nursing profession. In terms of hiring, men are preferred over women because of their physical strength and a perceived potential for better leadership. Also, due to their "renegade status" in a female-dominated profession, men are typically given more respect and encouraged to increase their education and enter the most prestigious specializations. Many male physicians even tend to treat male nurses as their equals, as do men in management positions (Chitty, K., 2005).

In terms of gender role expectations, men tend to earn more money than their female counterparts in the nursing profession. A study completed in 2002 revealed that male nurses do in fact earn about 12 percent more than female nurses (Chitty, K., 2005). Also, I found it interesting that married male nurses are viewed as the traditional breadwinners of their families and are considered more permanent, reliable employees (Chitty, K., 2005). It seems to me that this statement is grounded in traditional beliefs and I feel as though this thought process should change, with women and men being regarded as equally reliable, permanent employees.

I find it very interesting and disturbing that in a profession, such as nursing, overwhelmingly dominated by female employees, men still seem to have the upper hand (Brym and Lie, 2005). When I first thought about the issue of gender in nursing, my initial reaction before I did any research was that due to the fact that such an overwhelming majority of nurses are female must automatically benefit from this. I figured that male and female nurses in comparable jobs with comparable education must make relatively the same amount of money. I knew that men typically make more than women, even in female-dominated professions, but especially given the history of the discrimination of men in nursing and nursing being a female-dominated profession since its beginnings, I was shocked to find that male nurses make 12 percent more than female nurses.

I truly feel as though being armed with this new information and knowledge about gender role socialization and stereotypes helps me. If nothing else, it provides me with the knowledge and information so that I can enter situations educated and aware of what goes on in the "real world." Personally, I feel as though knowing what is expected of me as a female and how I am perceived because I am a female motivates me to act in ways to alter those expectations and stereotypes that I do not agree with. For me, the "what is perceived to be real becomes real in its consequences" statement does not apply in this situation. Being aware of those negative stereotypes and roles that we as females are expected to perform is enough to drive me to act in some way to change these negative perceptions.

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A Nurse's View of Workplace Gossip

By Jennifer Thew, RN, BSN, MSJ
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The Center for American Nurses

Name-calling, lunch money shakedowns, and wedgies are schoolyard hazards that kids have been dealing with for decades. While being picked on can be traumatizing, it's often assumed that as kids mature into adults, bullying behavior will end.

Sadly, bullying often continues into adulthood, moving from the school setting to the workplace. Disruptive behavior such as bullying, lateral violence, and verbal abuse is so common in healthcare settings that the Center for American Nurses recently released a position statement calling for zero tolerance to lateral violence and bullying in nursing work environments. The Joint Commission also proposed new standards that will require organizations to develop codes of conduct that define and address inappropriate workplace behavior.

The fact that these two organizations are advocating for policies to create healthier work environments is a positive step. But stopping disruptive behavior is not just the employer's responsibility. Nurses can take steps to combat bullying and lateral violence at their level as well.

Why is it so important to stop this behavior in its tracks? Bullying and lateral violence negatively impact staff morale, increase staff turnover, and decrease collaboration. Victims may experience physical and psychological problems that lead to greater rates of absenteeism and employee turnover.

We've all heard the saying, "Nurses eat their young," and we've probably seen behavior giving that statement credibility. Gossip, backstabbing, withholding of information, and shunning of co-workers are all forms of lateral violence.

When we witness these behaviors, it often makes us uncomfortable, and we're not sure what to do. Our unease often causes us to ignore rather than confront the situation because we are at a loss for how to respond.

At Empower Public Relations in Chicago, the CEO and his employees took an interesting approach to stop workplace gossip. All employees agreed that if someone was gossiping behind a co-worker's back, he or she was required to repeat it to that person. According to an article profiling the firm in Newsweek, this tactic helped workers become less distracted, made them more productive, and helped them communicate better.

Nurses could combat gossip on their own units by making a pact like the one at Empower. They also can make a vow to think about their words and actions and ask themselves, "Would I want someone to say this about or do this to me?"

At first it might be hard to stand up and say no to bullying, gossip, and bad behavior. You might feel uncomfortable or worry about becoming a victim yourself. But by uniting behind the goal of establishing a respectful workplace, nurses can support each other and further the profession.

Center for American Nurses Urges End to Lateral Violence and Bullying in Nursing Work Place

New position statement offers information and recommended strategies

Research has consistently shown an unacceptable level of violence in the workplaces of registered nurses (RNs). The sources of this violence include patients and their significant others, physicians, other healthcare personnel, and—perhaps most disconcerting—other RNs. Lateral violence and bullying specifically have been extensively reported and documented among healthcare professionals, with serious negative outcomes for registered nurses, their patients, and healthcare employers.

It is the position of the Center for American Nurses that there is no place in a professional practice environment for lateral violence and bullying among nurses or between healthcare professionals. All healthcare organizations should implement a zero tolerance policy related to disruptive behavior, including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior.

Background

Lateral violence (also known as horizontal violence, horizontal hostility, and intergroup conflict) is a specific type of violence that occurs between individuals at the same level of the organizational hierarchy. In nursing, it is nurse-to-nurse aggression. Lateral violence may be verbal or non-verbal and either overt or covert. The most common forms of lateral violence include non-verbal innuendo, verbal affront, undermining, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences.

Bullying is generally associated with individuals at different levels of power and authority, but can also occur nurse-to-nurse. Examples of bullying include undermining an individual's right to dignity at work, humiliation, intimidation, verbal abuse, victimization, exclusion and isolation; intrusion by pestering, spying, and stalking; repeated unreasonable assignments to duties which are obviously unfavorable to one individual; repeated requests giving impossible deadlines or impossible tasks; and implied threats.

"Lateral violence and bullying have profound and measurable negative effects on nurses, healthcare organizations, and patients," said Carrie Houser James, MSN, RN, CNA, BC, CCE, president of the Center for American Nurses. "The Joint Commission has recognized the negative effects of disruptive behavior on staff morale and turnover as well as on patient care and has proposed new standards for 2009 that will require organizations to have a code of conduct that defines disruptive and inappropriate behaviors and require a process for dealing with them. We applaud the Joint Commission for this effort and support the proposed standards."

Lateral violence and bullying affect the nurse as an individual, the nurse's colleagues, and ultimately patient care. Nurses who are the target of the violence and bullying as well as their colleagues may experience decreased job satisfaction, increased stress, and both physical and psychological effects. This can lead to negative outcomes for organizations including increased absenteeism and turnover. The problem of lateral violence and bullying is broad reaching and has clear implications in the current and future projected shortage of nurses, as well as the safety and quality of patient care.

Solutions

The Center for American Nurses has adopted a position statement that includes recommended strategies that nurses, employers/organizations, continuing education and academic programs, and nursing researchers can employ to eliminate lateral violence and bullying. A template for a zero tolerance policy and procedure has been developed as a part of the position statement.

"Zero tolerance must become a reality," said Dennis Sherrod, EdD, RN, president-elect of the Center for American Nurses. "This issue demands the immediate attention of every healthcare organization and every nurse."

Additional Information

The position statement can be viewed online at www.centerforamericannurses.org/positions/lateralviolence.pdf.

This position statement has been approved by a majority of the delegates who represent the Center's 42 organizational members, which include 41 state nursing associations, and by the Center's Board of Directors.

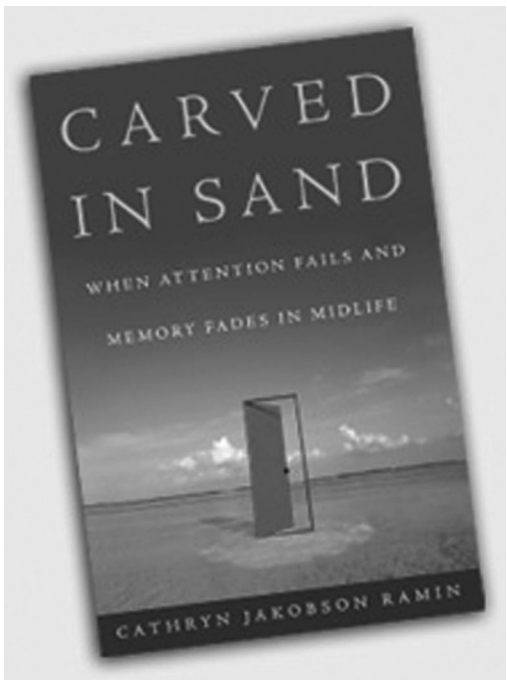
Lateral violence and bullying also will be addressed at the Center for American Nurses national meeting, which will take place in Washington, DC, June 23-24, 2008. Additional information can be found at www.LEADSummit2008.org.

Book Review: Understanding and Living With Memory Loss

Carved in Sand

by Cathryn Jacobson Ramin
Published by: 2007, Harper Collins, New York, NY
Reviewed by Penny Higgins, RN, EdD

A journalist who relies upon her memory not only to maintain a career, but to juggle children's schedules and a marriage, Cathryn Ramin was appalled to unexpectedly realize in her 40s that her memory wasn't as reliable as in her younger years. Furthermore, although she noticed similar lapses among her peers, she was still threatened by the thought of a more progressive deterioration. Was this pathology, information overload, or "normal" aging, and was there any way to be sure or to counteract the threats to her career and family life?



She pursues these questions with all the intensity of investigative journalism, but with a very personal intent. In the preface she summarizes her experience in this way: "For over two years, I traveled, meeting specialists and interviewing experts. I spent far too many nights in hotel rooms with polyester bedspreads. But here's the funny thing: I never felt alone, not for a minute. The memory-hungry crowd was with me, even when I had my head in the PET scanner. The answers I found are for all of us.

Although the details of midlife forgetfulness may vary from person to person, ultimately, we're all in the same boat. If you've been a member of the memory-hungry crowd for a while now, thanks for coming along for the ride. If you've only just joined us, welcome. You're in good company, and I'm delighted to tell you that you're *finally* going to find out exactly what's going on upstairs."

Although a very serious subject, Ramin's approach is exactly as in the paragraph above. She writes in a very conversational style, one that is very easy to understand. Although she uses accurate medical terminology as she describes the multiple testing her doctors used to verify the cause of her memory lapses, she does it in such a way that lay persons and health professionals can understand and appreciate. She has done her research thoroughly as evidenced by her endnotes, resources and bibliography. Anyone wishing to know more about a particular area may find a citation there. Of course the common denominator feared by all is Alzheimer's disease or some other chronic dementia, and these do occur in midlife. However Ramin makes very clear the host of other causes of our frequent lapses or memory blocks: undiagnosed hypothyroidism, diabetes, high blood pressure, sleep deprivation, anxiety, stress, and our insistence upon multitasking beyond our capabilities, alcohol, low levels of Estrogen, and drugs—even therapeutic ones. And she discusses the importance of finding and following the directions of an inquiring and supportive physician who will help you isolate the cause or causes of these disconcerting developments so early in life.

There is a discussion of the work of Yaakov Stern who has devoted much of his life to the phenomena surrounding memory loss, and his belief in "cognitive reserve" or neuronal padding over a lifetime. His research points up the importance of early stimulation, higher education, high IQ levels, but also the necessity of maintaining this stimulation through a combination of mental stimulation, physical activity and social interaction—difficult for some who have busy work and family lives. Other factors that Ramin found are similar to those that we have heard before, but with great intensity: regular exercise of some kind, socialization—even our workday lives have become less interactive with the use of e-mail as communication—puzzles and other mind challenging games. Learning a musical instrument or a new skill or language are very important techniques of building cognitive reserve.

What is important in this book for nurses and other health professionals? One reward is to help us realize our own behavior as normal aging and to be expected, not the onset of early dementia; and that there is help available. Don't remember what a certain drug is named or its purpose, the name of that patient you've been seeing every day for a week, what you were supposed to pick up for dinner on the way home? Talk with your healthcare professional, and look for reasons in your own life; try some of the interventions that Ramin and her many sources offer.

In working with patients it may be of even more value to assess their mental acuity and try to discover what might be the reason our teaching skills aren't successful. Look at your assessment and discuss with them what might be happening in their lives to reduce their memory skills, and help them identify some ways to enhance cognitive reserve and better live with an acute or chronic illness, its treatments and its challenges. It's a quick read, but one that offers many insights into enhancing up to one-half of our lives, and those of our patients, family and friends.

Safe Staffing—Not Just a Hospital Issue

School Nurse Shortage Puts Students at Risk

Safe Staffing for School Nurses

Safe staffing is a priority issue for nurses in all practice settings, and for one vital reason: to ensure the delivery of safe, high-quality health care. The nation's public schools represent one such setting that faces serious compromises to student safety and well-being due to a shortage of school nurses.

The important role of professional school nurses cannot be overstated, given the prevalence of chronic health conditions and other health-related needs among today's student population. The National Association of School Nurses (NASN) defines school nursing as "a multifaceted area of practice that promotes student health and safety as well as academic achievement." In addition to monitoring and treating a variety of health conditions, school nurses typically provide health education, first aid and emergency services, medication administration, immunization tracking, state-mandated health screenings, and many other services.

A growing body of evidence supports positive links between school nurse availability and improved health, school attendance and performance among students. Unfortunately, there are not nearly enough school nurses to care for the growing numbers of children with serious health problems. The current shortage of school nurses is due in large part to the lack of federal legislation mandating safe staffing plans and entry-level requirements for school nurses. Although federal laws require that school districts provide services to students with special needs, they do not require that such services be provided by school nurses. Consequently, states show wide variations in school nurse-to-student ratios and many states resort to the use of unlicensed personnel (for example, school secretaries, attendants, assistants) to provide healthcare services.

The ANA, along with the U.S. Department of Health and Human Services, the National Association of School Nurses (NASN) and several state organizations, recommends a minimum school nurse-to-student ratio of 1-to-750 for general school populations. Many states stipulate more stringent ratios for students with complex healthcare needs requiring frequent interventions. The central premise for recommending these ratios is that students have a right to safe, high-quality health care while in the school setting. The registered school nurse is the healthcare professional best suited to providing and coordinating the full range of healthcare services for student populations.

Adverse effects of school nurse staffing have prompted legal action by the nursing community. In 2007, the ANA and the ANA-California filed a lawsuit in the Superior Court of the State of California, claiming that the state Department of Education had violated the State Nursing Practice Act by calling upon unlicensed school personnel to administer insulin in the absence of a true emergency. Not only are children being placed at risk, but RNs, who are charged with providing training and oversight of unlicensed personnel, risk disciplinary action by the State Board of Nursing as a result of this directive. California has one of the highest school nurse-to-student ratios (approximately 1-to-2,700). The ANA has called upon the superintendent of public instruction to ensure that medications are administered to students only by persons legally authorized to do so, in accordance with California law.

If you function in this role or have children in K-12 educational programs, you may want to view ANA's recently adopted position statement on school nursing for children in these educational settings.

Confident Voices

The Q & A column for nurses facing difficult issues with communication, conflict and workplace dynamics

Welcome to a new column where communication and conflict specialist, Beth Boynton, RN, MS offers insights for nurses dealing with complex workplace dynamics. If you would like to have a situation considered for review in the next issue of ANA-Maine, contact Beth at: ConfidentVoices@verizon.net.

Dear Beth,

I am a med-surg staff RN and want to share a recent situation in our hospital regarding meal breaks. Apparently, our facility was reprimanded for the frequency of nurses not taking lunch or dinner breaks. Many of us don't have time and find it easier to skip the break rather than to try to leave the unit for a meal. As a result, HR has created a new policy that requires us to punch out for one meal break each shift. This has resulted in many of us punching out to meet the policy, but not taking the break. I personally resent being forced to take a break or lying about it, yet don't see any other options. Can you help?

Signed,

Punched-Out but Still On

Dear Punched-Out but Still On,

Thank you for a super example of nursing staff and administration becoming divided about something while an underlying issue may be lost or distorted. While the 'punch-out' policy may be a good-faith effort to address a labor requirement, attempting to control it, as you can attest, seems to be increasing resistance, contributing to a power struggle and creating a new problem.

I can understand your feelings of resentment about being forced to take a break or thinking that you have to lie about not taking one. I can also hear HR saying, *"We sent out e-mails to nurse managers who repeatedly informed staff about the importance of taking meal breaks, and it was the last straw when we got a warning from the Department of Labor."* I would understand their feelings of frustration too.

In addition to potential liability and labor issues about working while you are punched-out, and which an attorney would be better suited to answer, I wonder if there is an opportunity hidden in this conflict. What would happen if you spent some time reflecting on the following questions?

- How does this policy impact you?
- What would you need in order to take breaks?
- What questions could you ask HR that would help you understand their position?
- What could you do to make breaks more feasible and what limits do you have?

Meanwhile, I would also ask HR and perhaps your Nurse Manager to consider a similar process where some time is spent focusing on these questions:

- What is the impact on HR or the unit when nurses are not taking breaks regularly?
- How might HR or the unit support nurses in efforts to increase compliance?
- What questions might they ask nurses to gain a better understanding of their perspective?
- What could they do to help, and what limits do they have?

In doing this, both sides show ownership of part of the problem, a willingness to help solve it and a curiosity about each other's position. This in and of itself is not the solution, but it does contribute to an environment of respect and collaboration. This will allow you and your organization to get at the underlying problem(s), which may include workload, staffing, trust and delegating skills.

Nurses work long hours in very stressful environments. I remember working in med-surg and frequently not taking a break. In retrospect, I think there were several factors: unrealistic work assignments, an inability to articulate what I needed and a reluctance to include my break as a priority. Finding a way to take a rest or meal break is a healthy goal for you and your organization. Meditating, listening to music, or taking a walk may be alternative ways to take care of yourself for a few minutes during your shift and help prevent burnout.

If you are willing to be assertive and ask for what you need, I'm betting you and your colleagues can come up with some creative problem-solving ideas. Exploring underlying issues may shed light on a variety of related concerns. Progressive healthcare organizations that recognize the value of collaboration and are seeking to improve retention, quality and safety, will listen.

Who knows, perhaps you'll develop a new part-time "break-nurse" position or differential, obtain training on assertiveness or pilot some new scheduling model. Maybe you and your nurse and administration colleagues will come up with something entirely new.

Good luck with this and thanks for submitting your scenario.

Beth

Beth Boynton, RN, MS is a nurse trainer/consultant specializing in communication and conflict issues that impact nurses and other healthcare professionals. She is an adjunct faculty member with New England College's graduate program in Healthcare Administration. Original workshops for nurses include: Communication lab on Listening and Speaking-Up, Emotional Intelligence and Improving Workplace Dynamics. She is currently writing a book that focuses on helping nurses develop confident voices. She can be reached at bbbboynton@verizon.net, www.bethboynton.com, or 207-363-5604. You can also find her in the ANA NurseSpace as a Community Leader for the brand new blog: Communication and Conflict.

Sen. Collins Requests Support for Funding to Ease Nation's Nursing Shortage

In a letter to the chairman and ranking member of the Senate Appropriations Committee today, Sen. Susan Collins (R-ME) joined Sen. Barbara Mikulski (D-MD) in requesting that they retain the Senate funding level of $150 million for nursing education and workforce development programs as they complete the FY 2007 Labor, HHS, and Education appropriations bill.

"Our nation is facing a serious nursing shortage," said Sen. Collins. "In Maine there are 1,100 nursing vacancies. This number is expected to balloon to more than 5,200 over the next 15 years. At a time when the baby boomers are reaching retirement, and as more and more people are living longer and longer, with increasing healthcare needs, the ramifications of this shortage are worrisome."

Following is the full text of the senators' letter to Chairman Robert Byrd and Ranking Member Thad Cochran:

Dear Chairman Byrd and Ranking Member Cochran:

We applaud your efforts to pass a year-long continuing resolution to complete the FY 2007 appropriations bills in a timely and bipartisan way. During your work to complete the FY 2007 Labor, Health and Human Services, Education appropriations bill, we ask that you retain the Senate funding level of $150 million for Nursing Workforce Development (Title VIII, Public Health Service Act) programs at the Committee-passed level of $150 million. Moreover, we urge you to allocate additional funds to these important Title VIII programs.

The seven authorities under Title VIII provide the largest source of federal funding that focuses on the nursing shortage. They address nursing recruitment, education, and retention programs in schools of nursing as well as assist individual students with tuition assistance. In April 2006, 52 of our Senate colleagues supported us in requesting $175 million for these critical programs in FY 2007.

As you are aware, our healthcare system has been crippled by a nursing shortage that is only projected to worsen in coming years. In 2005, the Bureau of Labor Statistics estimated that healthcare facilities will need to fill more than 1.2 million RN job openings by 2014 to accommodate growing patient needs, the aging baby boomers, and to replace retiring nurses. We firmly believe that the Nursing Workforce Development programs provide a long-term solution that addresses the nursing workforce.

The Title VIII programs represent an important investment for patients. We encourage you to join us in this bipartisan effort to ensure that these programs have the resources required to educate, recruit, and retain enough registered nurses. We respectfully request the retention of the Committee-passed level of $150 million, and urge your consideration of providing additional appropriations in the final year-long continuing resolution for these important programs.

Your consideration of this request is greatly appreciated.

Source: Senator Susan Collins' web site at http://collins.senate.gov/public/continue.cfm?FuseAction=PressRoom.PressReleases&ContentRecord_id=59E1112E-802A-23AD-4AA8-B8E969648556&CFID=11981408&CFTOKEN=30548063

Hospitals in Step to Stamp out MRSA

by Debra Anscombe Wood, RN

Undaunted by formidable odds, the Maryland Patient Safety Center has set out to eliminate methicillin-resistant Staphylococcus aureus (MRSA), using an approach known as Positive Deviance, and has recruited 39 hospitals from Washington, Maryland, and Northern Virginia who have voluntarily joined its MRSA Prevention Initiative.

"These infections can cost people their lives and livelihoods," says Lisa Grubb, RN, BSN, CDONA, WOCN, director of infection control at Union Memorial Hospital in Baltimore, a participant in the program.

MRSA has kept area facilities on their toes.

St. Joseph Medical Center in Towson, Md., began an active MRSA prevention program in 2000 and has seen its rate of hospital-acquired infection decrease by more than half.

However, patients admitted with community-acquired MRSA have increased from 182 cases in 2000 to 750 cases in 2007.

MRSA Prevention Initiative history

The project began in 2006 with Johns Hopkins Hospital and Franklin Square Hospital Center, both in Baltimore, serving as two of six sites for a MRSA prevention initiative in collaboration with the Plexus Institute, the Centers for Disease Control and Prevention (CDC), the Delmarva Foundation, the Maryland Patient Safety Center, and the Southwestern PA MRSA Prevention Collaborative. Funded by the Robert Wood Johnson Foundation, the group pioneered teaching hospital personnel how to use Positive Deviance to control infection.

Positive Deviance is a social and behavioral change process based on the premise that in most organizations and communities there are people or groups who solve problems better than colleagues who have exactly the same resources. Solutions and best practices that are developed are then shared and implemented throughout the community.

Last year, seven more hospitals, including Union Memorial and St. Joseph, signed on, as the program expanded, thanks to $300,000 in funding from CareFirst BlueCross BlueShield of Owings Mills, Md.

"It's a real culture of change," says Leigh Chapman, RN, BSN, infection control coordinator at St. Joseph. "It's a transition for everyone to look at hospital-acquired infections and to start to obtain a getting-to-zero mentality."

Employing Positive Deviance

Franklin Square asked nurses on each unit what they were doing to prevent MRSA and what barriers existed to fighting infections. In every group, nurses consistently expressed how they successfully overcame impediments to follow infection control policies, such as a lack of readily accessible gowns. Then, they came up with solutions.

"Positive Deviance gives people the luxury of taking the time to explore their practice and to critically reassess for themselves what they need to do," says Patricia Norstrand, RN-BC, MS, senior director of quality, risk and safety at Franklin Square.

Mary Beth Thier, RN, BSN, CCRN, BC, education specialist at Franklin Square, says the technique differs from best practices in that no one tells the unit what to change.

"It's ownership at the practitioner level rather than at the facilitator level. It's a subtle but critical difference," Thier says. Once something works, that unit may share the idea with another unit or another hospital, but it's not directive."

Individual hospital initiatives

Because Positive Deviance draws on nurses' and other health professionals' successes and ideas, hospitals have implemented various strategies to decrease hospital-acquired MRSA infections. Universally, they are working to improve hand hygiene, although they are trying different methods. St. Joseph deployed hand hygiene champions on every unit. It also taught staff a cadence to repeat while washing their hands.

St. Joseph removed Bibles from patient rooms and instead offered a personal Bible in admission packets. Chapman taught the environmental staff about MRSA and proper cleaning techniques.

One unit at Franklin Square decided to place hooks outside patient rooms so residents could hang up their lab coats. In the PACU, nurses suggested putting a green dot on the wristband of MRSA-infected patients and placing a disposable stethoscope and blood pressure cuff on the stretcher.

"They quickly know isolation patients as soon as they roll through the door," Thier says.

Perioperative nurses at Union Memorial devised a plan to decrease the transmission risk for MRSA or other resistant organisms. The hospital electronically tracks patients with the disease, so the OR team can check their patients' status. If positive, a nurse goes to the floor to check the patient in, rather than bringing him or her to the pre-op waiting area. They maintain isolation while in surgery.

The three hospitals actively screen all patients admitted to certain units for MRSA. The action identifies patients colonized with the bacteria. Those found positive are placed on contact isolation.

Union Memorial nurses collect a nasal swab of patients admitted to the critical care unit (CCU) and send it to the lab for a culture. The CCU staff has achieved 96% compliance with admission cultures. Repeat cultures are performed weekly and on discharge. Its rate for hospital-acquired MRSA bacteremia has consistently been zero, Grubb says.

Franklin Square tests anyone admitted to its two ICUs or step-down unit with a test that produces results within two hours. Franklin Square has noted a 66% decline in new isolates of MRSA since its program began in August 2006.

St. Joseph has taken a slightly different approach. It began surveillance five years ago. While it collects a nasal swab from all patients admitted to the medical-surgical ICU and runs a rapid test, which produces results within six hours, it places at-risk patients, including IV drug users and nursing home patients, in isolation immediately.

If the test comes back negative, the patient comes off isolation. Tests are repeated at seven days and upon discharge. Compliance on admission is greater than 90% and ranges from the upper 80 percentile to better than 90% at discharge. Few patients stay in the ICU seven days.

"We're fighting something we can't see, so we need to make it real," Grubb says. "We need to realize we all make a difference in this fight."

New Patient Care Innovations in a Holistic Environment: The Planetree Model…featuring an interview with Linda Sharkey, MSN, RN

by Amanda Rosenkranz, MSN, RN
Reprinted with permission from the Center for American Nurses

Linda Sharkey has worked in a variety of acute care settings as a hospital supervisor, nurse manager for reviewers of defense malpractice cases, assistant director and director. In 2003 she joined Fauquier Health System and is Vice President of Patient Care Services/Chief Nurse Executive. She currently serves on the boards of the Fauquier Free Clinic, Piedmont Home Care, and the American Organization for Nurse Executives. Ms. Sharkey received Inova Health System's Manager of the Year and Innovation awards in 2002, was a finalist in *Nursing Spectrum's* "Advancing and Leading the Profession" nursing excellence award in 2007 and received the Planetree Spirit of Caring Award in 2007. She has served in a key position during the planning and implementation of the Planetree model at Fauquier Hospital in Virginia, which is a patient-centered holistic approach to health care. In 2007, Fauquier Hospital became the fifth hospital internationally to become a *Designated Planetree Patient-Centered Hospital*.

We recently talked with Ms. Sharkey regarding the Planetree model and what nurses can do to implement some of the changes that promote this individualized patient care environment.

Center: Can you explain the guiding principles behind the Planetree model?

Ms. Sharkey: A guiding force behind the Planetree model is to restore autonomy to the patient in making their own healthcare decisions by providing them information. Treating our patients with dignity, respect and providing information needed for patients to care for themselves. Forward-thinking institutions whose physical environments, policies and practices reflect a commitment organization-wide to providing healthcare the way the patient wants it delivered can make changes, such as creating nursing stations with lower walls and counters to promote an environment that is void of barriers. Care partners, whether they are family members or friends, are encouraged to help guide the patient through the hospitalization process and advocate for the patient to care for themselves. Integrative therapies are also used, such as pet therapy, massage and yoga. Community assessments determine the services that are offered.

Center: What factors influenced your hospital to adopt this model?

Ms. Sharkey: It was the right thing to do for our patients, staff and community to meet their individual needs in a healing environment. In addition, it provides a competitive edge and is recognized by Joint Commission (in the form of a special quality award for exceeding accreditation standards).

Center: What planning was needed to implement the Planetree model?

Ms. Sharkey: There was a strategic alignment around this philosophy: staff and team retreats were completed and a steering committee was created with staff included. The plan involved a grass roots approach with the staff. During the planning, there was construction so there was an architectural adaptation of this philosophy. For example, all of our rooms are private, with a day bed for family to stay in the room with the patient. There is also a kitchen located on each unit for patients and families.

Center: What has been your hospital's greatest challenge in the planning and implementation of the Planetree model?

Ms. Sharkey: This is a total culture change: the Planetree model is woven into everything that we do; it was instinctive for staff to say they 'already do it' regarding incorporating Planetree principles into patient care. The culture change involved saying how we were going to achieve a holistic model: changing visiting hours, upholding patient rights and being there for the patient. It is a never-ending journey.

Center: What would you tell nurses about what they can do to implement changes that embrace the Planetree philosophy?

Ms. Sharkey: The nursing leaders need to embrace the philosophy and support their staff as they learn about the model. Some of the actions nursing leaders can take are having their staff educated on how the individualized care model improves patient outcomes. In addition, all departments and staff need to engage in adopting the Planetree philosophy since we all play a part in the patient's care.

Center: What has been your hospital's greatest challenge in adopting the Planetree model?

Ms. Sharkey: Educating all staff on how they are a part of the Planetree philosophy and embracing it. We are all one big team and we need to make sure we can deliver what we say we will deliver.

Center: What is your vision for nursing regarding making changes to promote a healthy work environment?

Ms. Sharkey: We need to look at the patient as a person with feelings and look at the whole person. Nurses also need to examine how we take care of each other, what nurses do really matters and needs to be recognized. We have a wellness center for staff, and our next step is to create a concierge service that takes care of all of the things nurses do on their days off (groceries, dry cleaning). It's important that we take care of our own staff so that they can take care of our patients, families and community.

Interested in an opportunity to join CE Reviewers on the ANA-MAINE Continuing Education Committee?

If you are an ANA-MAINE member who would like to join our collegial, supportive group of CE reviewers and have a minimum of BSN and experience in education, please contact Dawn at anamainece@gwi.net or (207)938-3826) to request a committee member application.

ANA-MAINE is Maine's accredited approver of continuing nursing education by the American Nurses Credentialing Center's (ANCC) Commission on Accreditation. As a committee member you will be oriented to review continuing education applications using the latest ANCC criteria. If you have questions, please contact Ruta at (207)733-2385 or e-mail her at CEChair@anamaine.org.

Continuing Education Calendar for Maine Nurses

ANA MAINE
AMERICAN NURSES ASSOCIATION MAINE

Although we attempt to be as accurate as possible, information concerning events is published as submitted. We do not assume responsibility for errors. If you have questions about any event, please call the event planner directly.

If you wish to post an event on this calendar, **the next submission deadline is July 5 for the Summer issue.** Send items to publications@anamaine.org. Please use the format as you see below: date, city, title, sponsor, fee and contact information. There is no charge to post an educational offering.

Advertising: To place an ad or for information, contact sales@aldpub.com.

ANA-Maine is the ANCC-COA accredited Approver Unit for Maine. Not all courses listed here provide ANCC-COA credit, but they are printed for your interest and convenience. For more CE information, please go to www.anamaine.org

To obtain information on becoming a ANCC-COA CE provider, please contact anamaine@gwi.net

USM/CCE indicates the class is offered through University of Southern Maine/Center for Continuing Education. For course descriptions, visit www.usm.maine.edu/cce or call 207-780-5900 or 800-787-0468 for a catalog. Most classes are held at the new Abromson Community Education Center in Portland, conveniently located just off I-295. Free parking nearby.

CCSME indicates class is held by the Co-Occurring Collaborative of Southern Maine.

PESI HealthCare seminars in Maine, visit http://www.pesi.com

May 2008

1-June 14 Portland, USM Continuing Education. **Putting It All Together! An RN Refresher Course.** Contact 207-780-5900 or www.usm.maine.edu/cce

Session 1: Neurological System—Thursday, May 1, 6–9 p.m.
Session 2: Vascular System—Thursday, May 8
Session 3: Respiratory System—Thursday, May 15
Session 4: Cardiac System—Thursday, May 22
Session 5: Cardiac System—Thursday, May 29
Session 6: Gastrointestinal System—Thursday, June 5
Session 7: Renal System—Thursday, June 12
Session 8: Skills Lab—Saturday, June 14, 9 a.m.–4 p.m.

2-3 Portland, USM Continuing Education. **The Chakra Dance: An Intensive Exploration of Energy, Emotions and Illness.** Contact 207-780-5900 or www.usm.maine.edu/cce

3-5 Portland, USM Continuing Education. **Certificate Program in Holistic Health Care/Session 1.** Contact 207-780-5900 or www.usm.maine.edu/cce

5 Portland, USM Continuing Education. **Certificate Program in End-of-Life Care.** Contact 207-780-5900 or www.usm.maine.edu/cce

5 Portland, PESI. **Ensuring Kids' Health at Camp: Preparing for the Adventure!** For additional discount information: 800-843-7763, or www.pesihealthcare.com

5-6 Portland, USM Continuing Education. **DBT: Training for Therapists—How to Teach the Skills.** Contact 207-780-5900 or www.usm.maine.edu/cce

5, 12 and 19 Portland, USM Continuing Education. **Resolving Workplace Conflict: A Three-Day Intensive.** Contact 207-780-5900 or www.usm.maine.edu/cce

9 Saco, Sweetser Training Institute. **Supporting Families in "Raising Up" Children.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

12-13 Portland, USM Continuing Education. **Using Motivational Interviewing with Chronically Ill Patients.** Contact 207-780-5900 or www.usm.maine.edu/cce

14 Portland, PESI. **Childbirth Strategies for Normal and At-Risk Labors.** $169. For additional discount information: 800-843-7763, or www.pesihealthcare.com

14-15 Portland, USM Continuing Education. **A Holistic Approach to Psychological Trauma and Addiction Treatment.** Contact 207-780-5900 or www.usm.maine.edu/cce

16 Portland, USM Continuing Education. **Certificate Program in Case Management.** Contact 207-780-5900 or www.usm.maine.edu/cce

16 Brunswick, Sweetser Training Institute. **Dealing with Resistance to Change.** 9a.m.-noon $55. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

19-20 Portland, USM Continuing Education. **Mindfulness, Interpersonal Neurobiology and the Work of Byron Katie: Clinical Application.** Contact 207-780-5900 or www.usm.maine.edu/cce

19-20 Brunswick, University of New England Maine Geriatric Education Center. A 24-hour **Health Literacy Program** for all health professions faculty. The first 16 hours to be held at the Captain Daniel Stone Inn; the last 8 hours to be completed online, and by completing a brief curriculum planning project. $150 for both in-state and out-of-state participants; special Inn rate of $79/night. For more information: 207-602-2124

Continuing Education Calendar for Maine Nurses

23 Saco, Sweetser Training Institute. **Sleep Disturbances & Psychiatric Disorders in Children & Adolescents.** 9a.m.-noon $55. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

30 Brunswick, Sweetser Training Institute. **Forgiveness: The Missing Peace.** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

June 2008

5-6 Portland, USM Continuing Education. **Beginning Nursing Leadership and Management Concepts: Tools and Practical Strategies for Everyday Success.** Contact 207-780-5900 or www.usm.maine.edu/cce

6 Saco, Sweetser Training Institute. **Cutting.** 9a.m.-1p.m., $64. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

11 Portland, PESI. **Managing Children with Infectious Diseases.** $169. For additional discount information: 800-843-7763, or www.pesihealthcare.com

13 Brunswick, Sweetser Training Institute. **CBT (Cognitive Behavior Therapy).** 9a.m.-4p.m., $84. For further information contact Jodie Hansen, organizational trainer: 207-294-4761 or jhansen@sweetser.org

13 & 27 Portland, USM Continuing Education. **Certificate Program in Case Management.** Contact 207-780-5900 or www.usm.maine.edu/cce

19 Bangor, PESI. **Functional Assessments and Exercise Programming.** $179. For additional discount information: 800-843-7763, or www.pesihealthcare.com

20 Bangor, PESI. **Functional Assessments and Exercise Programming.** $179. For additional discount information: 800-843-7763, or www.pesihealthcare.com

25-27 Portland, USM Continuing Education. **Sport Psychology Institute.** Contact 207- 780-5900 or www.usm.maine.edu/cce

July 2008

9-11 Portland, USM Continuing Education. **Health Psychology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

16-18 Portland, USM Continuing Education. **Adult Psychopathology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

23-25 Portland, USM Continuing Education. **Childhood Psychopathology Institute.** Contact 207-780-5900 or www.usm.maine.edu/cce

ANA News

ANA Part of Senate Roundtable on Value-Based Purchasing

On March 6, the ANA participated in the Senate Finance Committee's Roundtable discussion of the Hospital Value-Based Purchasing (VBP) Program. The VBP program is an attempt to relate Medicare Part B reimbursement to quality—versus quantity—of care. Quality measurement is a key aspect of VBP, along with performance-based financial incentives. Committee Chairman Max Baucus (D-MT) and Ranking Minority Member Charles Grassley (R-IA) appeared at the roundtable.

The 20 participants included representatives of the Centers for Medicare and Medicaid (CMS), National Quality Forum, and General Accounting Office; physician specialty groups, hospitals, Blue Cross/Blue Shield, and health education, business and policy groups. Dr. Carol Watson appeared on behalf of the American Organization of Nurse Executives (AONE). Isis Montalvo, RN, MS, MBA, manager, Nursing Practice and Policy, submitted a written statement and spoke at the roundtable on behalf of the ANA.

Moderator John Inglehart, founding editor of *Health Affairs*, discussed a basic problem posed by the VBP program and how hospitals, doctors and nurses can come together and work in concert to achieve its goals. He cited the need for an "alignment of reporting by professionals" working in health care. Inglehart quoted a key passage from ANA's written statement that the current CMS plan "fails to include the central provider of care in any given setting—the nurse—and fails to recognize nurses' extensive contributions to patient outcomes." He then turned to ANA's Isis Montalvo, and asked her directly how CMS could amend its plan to include nurses.

Montalvo responded eloquently and authoritatively that nursing has been involved for many years in the measurement and improvement of quality in patient care, through the development and management of the National Database of Nursing Quality Indicators (NDNQI). She discussed how NDNQI works, and the extreme importance of including nursing staffing in performance and quality indicators. Her comments were extremely well received by the roundtable participants as well as the moderator.

Several speakers echoed the importance of nurses in maintaining and measuring quality of care including Mercy Hospital (Iowa), site of the VBP demonstration project. The CEO of Billings Clinic, Billings, MT, who is a member of MedPAC (which advises Congress on Medicare policy), even said that "it's all about the nursing." A physician from the Society of Hospital Medicine suggested that nursing costs and outcomes should be "carved out" and looked at separately because of their importance. The CEO of the American Hospital Association spoke of the importance of "physician-nurse collaborative efforts." Dr. Watson of AONE noted that nurses are responsible for a great deal of quality reporting, but unfortunately those duties also take nurses away from the bedside.

Inglehart suggested that the ANA meet with CMS officials, and present specific and concrete measures to fully integrate nursing into the Value-Based Purchasing Plan. Efforts are underway to follow up on that suggestion. Since the National Quality Forum has even suggested expanding the VBP program beyond Medicare Part B (and therefore beyond inpatient care), this could be a crucial opportunity to get in on the ground floor of what may become a far-reaching program.

Source: Eileen Shannon Carlson (2008). JD, RN, ANA Capital Update, 6 (3) at http://www.capitolupdate.org/Newsletter/index.asp?nlid=203&nlaid=963.

The ANA is the only full-service professional organization representing the interests of the nation's 2.9 million registered nurses through its 54 constituent member nurses associations. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

ANA President Joins Senator Clinton on Campaign Trail

Showing the country that nurses are leaders in the healthcare arena, their voices loud and clear, ANA President Rebecca M. Patton, MSN, RN, CNOR traveled to Tacoma, WA, to reaffirm the American Nurses Association's endorsement of Sen. Hillary Clinton (D-NY) for president.

With Washington State Nurses Association members onstage and in the audience holding "RNs for Hillary" signs, Patton asserted before an enthusiastic crowd of 5,000:

"We at the American Nurses Association believe that Hillary Clinton has shown a commitment to implementing real change in our healthcare system to ensure high-quality, affordable and accessible care for all Americans." Moreover, Patton stressed that "Hillary has recognized the importance of educating, recruiting, and retaining RNs, and she has shown her commitment to nurses by supporting increased funding which helps address the critical nursing shortage." In addition to her travels to Washington State that included a rally in Seattle, Patton has also served as a surrogate speaker for Sen. Clinton in Ohio leading up to the March 4 primary. Patton also addressed student nurses, nurses and faculty at Case Western Reserve and Cleveland State on Feb. 28, 2008.

The Road to Victory! Get Involved Today!

Registered nurses represent the largest group of healthcare professionals. You have the chance to use your power at the ballot box to make health care a priority and to ensure that the concerns and goals of the nursing profession are represented on the national agenda!

Source: ANA Capital Update, 6 (2) at http://www.capitolupdate.org/newsletter/.

ANA News

ANA Board Adopts Revised Health System Reform Agenda and Strategic Plan

As part of its long-standing and aggressive education and advocacy work for guaranteed affordable and accessible health care for all, the ANA today released *ANA's Health System Reform Agenda,* an update of the organization's 2005 call for comprehensive healthcare reform. ANA's *Health System Reform Agenda* calls for dramatic changes in the U.S. healthcare system in order to achieve guaranteed, high-quality, affordable health care for all.

In addition to addressing healthcare cost, quality and access, ANA's agenda confronts the under-reported challenge of providing a healthcare workforce that is capable of providing high-quality, accessible care in a rapidly changing healthcare system. ANA, with its unique perspective and as a recognized leader in healthcare policy formation, spotlights for the nation the necessity of developing and supporting a quality healthcare workforce as a vital element for successful health system reform.

"With the 2008 presidential election in full swing, healthcare reform has grabbed the nation's attention as a front-burner priority—and for good reason," remarked ANA President Rebecca M. Patton, MSN, RN, CNOR. "Nurses have a pivotal perspective to share; we are the glue holding much of the current broken healthcare system together. We witness the daily instability and problems patients face. No one works more closely with patients than nurses." Patton continued, "*ANA's Health System Reform Agenda* brings the largest single group of healthcare professionals in the U.S.—registered nurses—to this urgent national discussion."

In its newly adopted strategic plan, ANA emphasizes "safe staffing" as a priority concern for nurses and patients alike in health system reform: "A patient may have the best insurance coverage available, but if there are not enough registered nurses on the unit to give that patient the care and attention he or she requires and deserves, it remains inadequate." "Nurses must be a central part of a hospital's everyday staffing decisions, so that patients' safety can come first," said Linda J. Stierle, MSN, RN, CNAA, BC, CEO of the ANA.

Second, ANA shines the light on current barriers that preclude many nurses from providing the full array of quality care they are educated and licensed to give patients. Advance practice registered nurses (APRNs), those nurses who have achieved a master's level or higher education in nursing, are reliable and tested providers of primary care. "These nurses can prescribe, diagnose, and treat illness, but they are not being fully utilized to provide urgently needed primary care, despite the shortage of primary care physicians," said Cynthia Haney, JD, ANA's Nursing Practice and Policy Senior Fellow. Registered nurses are specialists in health education, disease prevention, chronic care management and coordination of care—all elements that experts believe must be present in a superior health system.

ANA's advocacy for guaranteed affordable health care for all, reflected in its new agenda, is rooted in decades of policy work. In 1989, ANA's "Task Force on Health Policy Support of Access, Quality and Cost Efficiency" began a collaboration with the broader nursing community, to create *Nursing's Agenda for Health Care Reform* (ANA, 1991), a blueprint for reform that was endorsed by 60 nursing and healthcare organizations.

In 2005, noting that America's healthcare system had continued a pattern of fragmentation and increasing costs over the intervening years, ANA's Congress on Nursing Practice and Economics updated the 1991 document, adding an essential set of recommendations calling for both public and private support and development of the nursing workforce. For health care to be effective, safe, fair, and affordable, there must be an adequate supply of well-educated, well-distributed and well-utilized registered nurses.

This key policy document was revised again in January of 2008, to reflect the rapidly accumulating, most current scientific evidence underlying elements of the plan. Renamed *ANA's Health System Reform Agenda*, this urgent call for health system reform is part of ANA's professional and ethical obligation to maintain the integrity of nursing practice and pursue the best possible health care for the nation's people.

To view the *ANA's Health System Reform Agenda,* please visit this link, http://cms.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HSR.aspx.

ANA Critical Of President's Proposed Budget

FY 2009 budget shows severe cuts in nursing programs

SILVER SPRING, MD–In response to the president's proposed budget, the American Nurses Association criticizes what it believes is the insufficient funding for Title VIII Nursing workforce development programs. For fiscal year 2009, President Bush recommends $109,853 million in funding for Title VIII programs; this is a decrease of $46,193 million, or 29.6 percent from FY2008 funding. Title VIII programs serve to fund education programs, recruit new nurses into the profession, promote career advancement within nursing and recruit nurses to critical shortage areas.

The president's proposal completely eliminates funding for Advanced Education Nursing Programs, which are currently funded at $61,875 million. These programs prepare nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists, nurse educators, nurse administrators and public health nurses.

"Now is the time to invest in nursing. The current nursing shortage has reached a critical point where the quality of patient care is impacted," said ANA President Rebecca M. Patton, MSN, RN ,CNOR. "Increased funding for Title VIII programs is vital to save thousands of lives, and millions in health care costs linked to avoidable complications associated with the shortage. That is why ANA plans to request $200 million in Title VIII funding when Congress begins its work on the budget."

The decrease in Title VIII funding represents only a portion of nearly a billion dollars in total cuts to the Health Resources and Services Administration (HRSA). ANA is deeply concerned about additional drastic cuts that would severely impact or eliminate other HRSA programs, including Title VII Health Professions the Office of Rural Health, and Public Health Improvement.

ANA Advocates For Critical RN Representation On The U.S. Department Of Health And Human Services Secretary's Advisory Committee On National Health Promotion And Disease Prevention

SILVER SPRING, MD–In advance of a series of regional hearings being convened by the U.S. Department of Health and Human Services (HHS) to discuss the objectives for "Healthy People 2020," the American Nurses Association (ANA) is calling for representation of the nursing profession and nursing community on the HHS Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. The advisory committee is charged with developing a vision and a plan for improving the nation's health by the year 2020.

"The Advisory Committee is comprised of several distinguished physicians, academicians, and health administrators. However, the failure to appoint a representative from the single-largest health profession–which is at the forefront of health promotion and disease prevention–represents a failure to recognize both the crucial role that nurses play as well as the need to integrate nurses into any health promotion and disease objectives and plans, and sends the wrong message to the nursing and public health communities", said Rebecca M. Patton, MSN, RN, CNOR, President, ANA.

ANA urges its members to call upon HHS to name a registered nurse to the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020 through the federal government's public comment Web site, http://www.healthypeople.gov/hp2020/comments/default.asp.

Comments received through this site by May 1, 2008 will be reported at the June 2008 meeting of the Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020.

House Passes Mental Health Parity Legislation, Negotiations on House-Senate Compromise Continue

On March 5, the House approved legislation requiring health plans offering mental health coverage to provide the same benefits for mental illness as they do for other medical conditions. The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424), which passed by a vote of 268-148, still differs in a few important ways from S. 558, the Mental Health Parity Bill passed by the Senate in September of last year.

Thanks to all who contacted their members of Congress to express support for H.R. 1424. Although there is more work to be done to ensure enactment of Mental Health Parity legislation, House passage of the bill was a vital and necessary step toward the ultimate goal.

While neither the House nor the Senate bill mandates insurance coverage of mental health care, the bills would prohibit insurers that offer mental health benefits from imposing financial requirements (such as deductibles, co-payments, and annual and lifetime limits) or treatment limitations (including limits on treatment frequency, number of visits and length of stay) that are more restrictive than those applied to medical and surgical coverage.

Although the Senate bill included an amendment that alleviated some concerns about preemption of state laws, the House and Senate bills still differ on issues including covered conditions, in- and out-of-network coverage, and medical management. One of the most contentious differences between the two bills is the House provision requiring employers to cover all illnesses listed in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV). The American Psychiatric Association publishes the DSM-IV, which is viewed as a comprehensive listing of mental health disorders for both children and adults. It also lists causes of disorders, statistics and information on treatment research. H.R. 1424 supporters believe this provision is important to ensure true parity in health coverage, while opponents say the DSM-IV language would allow coverage for conditions such as jet lag and caffeine addiction.

The House "paid for" H.R. 1424 in part by including provisions that would prohibit physicians in Medicare from referring patients to hospitals in which they have an ownership interest, with the ability to grandfather existing physician-owned hospitals. A second funding measure would increase the size of prescription drug rebates pharmaceutical companies must provide state Medicaid programs. Neither provision is universally favored by members of Congress, and the White House has openly opposed the controls on physician-owned hospitals. In fact, in a March 5 statement the administration expressed opposition to H.R. 1424 because of the funding provisions as well as the mandated conditions covered in what it calls "confusing pre-emption provisions."

Next Steps

Mental health parity legislation has come further this Congress than any time in recent memory, but with a few key differences between the House and Senate bills, some difficulty identifying funding sources to offset the bill's price tag ($4.3 billion over 10 years), and political dynamics between the two chambers, it has been difficult to achieve final compromise legislation that could pass both chambers and be signed by the president.

S. 558 was crafted with input from insurers, employers, and mental health groups, and represents a compromise approach that many believe offers real hope for passage. Insurers and employers who have long opposed mental health parity legislation in the past have endorsed the bill, as have many mental health and health care groups who, after years of stalemate on the issue, are anxious to advance change. In order to pass the Senate and be signed by the president, any compromise will almost certainly need to have continued support of insurers and employers, some of whom actively opposed the House bill when it came to the floor.

Parity proponents in both chambers say they are committed to sending parity legislation to the president before the end of the 110th Congress; both chambers have been engaged in discussions to resolve these differences. Bolstering this effort, a bipartisan group of 25 senators have signed a letter to Senate leadership expressing support for the intent of both bills and urging the passage of a compromise before Congress adjourns.

Senators Offer Compromise Bill

On March 18, two of the three lead Senate parity bill sponsors, Sens. Kennedy (D-MA) and Dominici (R-NM) offered draft compromise legislation to the House. The offer included the Senate-passed small employer exemption, language on out-of-network coverage that is more in keeping with the House approach, and used the House bill language on transparency. However it did not incorporate the House's DSM-IV coverage provision.

The House sponsors are not expected to respond to the proposal until after March 31 when Congress returns from recess.

ANA is committed to ensuring access to quality health care for all, and has expressed support for both the House and Senate parity bills. It is critical that we end the longstanding insurance discrimination and barriers to care experienced by those facing mental illness. ANA will work to advance mental health parity legislation that achieves this goal.

Source: Michelle Artz (2008). ANA Capital Update, 6 (3) at http://www.capitolupdate.org/Newsletter/index.asp?nlid=203&nlaid=969.

MedPAC Staff Defines "Primary Care Providers" to Include Nurse Practitioners

The Medical Payment Advisory Commission, or MedPAC, was created in 1997 to advise Congress on issues involving Medicare. While cost issues are naturally a major priority, MedPAC is also charged with analyzing access to care and quality of care. Jennie Chin Hansen, RN, MSN, of the AARP, is one of the 17 members of MedPAC. ANA staff attended MedPAC's public meeting on March 5-6, 2008.

"Promoting the Use of Primary Care" was one of the topics presented by MedPAC staff and discussed by the commissioners. They recognized that while primary care providers (PCPs) provide valuable care coordination and reduce costly specialists' services, PCPs are in short supply, and their services are undervalued, including by Medicare.

The MedPAC staff explicitly recognized that nurse practitioners qualify as primary care providers. "Primary care" was defined as: "Comprehensive health care provided by personal clinicians who are responsible for the overall, ongoing health of their individual patients." The definition of primary care providers specifically included "nurse practitioners who train in primary care fields," as well as a "team of physicians and non-physician providers." The MedPAC staff recommended "a fee schedule adjustment to promote primary care," and once again, explicitly included nurse practitioners as one of the "selected practitioners" eligible for such fees.

MedPAC Staff Defines "Medical Homes" to Include Nurse Practitioners

The **"medical home"** concept rewards primary care providers for coordination of care, especially for complex patients with multiple conditions. As we discussed in the February 2008 Capitol Update (see "In the States: What's in a Name?"), nurse practitioners are not eligible to be considered as a medical home in many states, as well as in the first Medicare demonstration project on medical homes.

MedPAC staff also indicated that nurse practitioners who "furnish primary care" would be eligible to qualify as a medical home, as long as they meet the other criteria applicable to any other primary care provider. These criteria would require the PCP to have, use or provide: health information technology, care management services, 24-hour patient communication and access, up-to-date records of advance directives, and accreditation or certification from "an external accrediting body."

The MedPAC staff's concepts for improving primary care and creating medical homes were well-received by the MedPAC commissioners, with some concerns expressed about increasing costs overall. One commissioner, a physician, even mentioned the need to "unleash the creativity of primary care providers and nurse practitioners" to provide better coordination of care. MedPAC's official report to Congress will be issued in June 2008, and then we will know if the commission has adopted these definitions of primary care providers and medical homes.

Source: Eileen Shannon Carlson, JD, RN (2008). ANA Capital Update, 6(3) at http://www.capitolupdate.org/Newsletter/index.asp?nlid=203&nlaid=968.

Maine Coast Memorial Hospital Receives Top Award for Excellence in Treating Heart Attack Patients

Maine Coast Memorial Hospital has been chosen to receive one of sixteen 2008 Leadership Awards for Clinical Excellence in treating heart attack patients by VHA Inc., a national health care alliance serving more than 1,400 not-for-profit hospitals nationwide. MCMH will be presented with the top award at VHA's Leadership Conference in Philadelphia on May 4.

"This award honors organizations that have differentiated themselves around national performance standards by achieving exceptionally high levels of performance," said VHA's President and CEO Curt Nonomaque.

To be considered, a healthcare organization had to place among the top 10% of hospitals, measured by nationally accepted indicators of quality for the last 2 quarters of 2006 and all of 2007. "Maine Coast Memorial Hospital had performance ratings of 100% in 6 out of 7 measures, exceeding state and national averages," said Beth Bunker-Anderson, Care Management Quality Leader for the hospital.

"This award represents the conscientious teamwork of many, starting with the EMTs on the ambulances, the emergency room staff, doctors and nurses, and cardio-pulmonary therapists, who are dedicated to treating heart attack patients promptly and effectively, using best practice standards." Ms. Bunker-Anderson, RN, CPHQ, has headed the hospital's quality program for 10 years.

"Timely and effective care for heart attack patients saves lives and health care dollars," said Trent Haywood, M.D., J.D., chief medical officer at VHA. "Maine Coast Memorial Hospital is a shining example of what can be achieved when a hospital's actions are guided by the pursuit of clinical excellence."

VHA, Inc is a national alliance providing management services and supports the formation of regional and national networks to help members improve their clinical and economic performance. Its members include more than 1,400 not-for-profit hospitals and more than 21,000 non-acute care organizations nationwide.

Beth Boynton Added to ANA-Maine Speakers Bureau

ANA-Maine member Beth Boynton, an organizational development consultant specializing in issues that impact nurses and other healthcare professionals, has joined the ANA-Maine Speakers Bureau. Beth is a coach, facilitator, and trainer for topics related to communication, conflict, teambuilding and leadership. As an adjunct faculty member with New England College's graduate program in Healthcare Administration, she teaches courses in Organizational Communication, Conflict and Negotiations and Organizational Leadership and Management.

Beth has published several professional articles; her column, *Confident Voices*, a question-and-answer format that addresses communication, conflict and workplace dynamics, is featured in the ANA-Maine Journal. She is currently writing a book and is available to speak on related material. You can view her Web site, www.bethboynton.com for more information.

Improved Central Line Care to Prevent Health Care-Associated Infections

Statement of the Problem and Impact: The Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network defines a central line as a catheter whose tip terminates in a great vessel including the aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, and common femoral veins (*1*). Central line catheters—including peripherally inserted central catheters, tunneled and non-tunneled catheters, implanted ports and hemodialysis catheters—are essential in modern medical practice but increase a patient's risk for infection by disrupting skin integrity (*2*).

Studies have shown that microbes that colonize catheter hubs and the skin surrounding the insertion site are the source of most bloodstream infections (BSI) (*3-5*). About 90% of catheter-related bloodstream infections occur with central venous catheters (*6*). Infection may spread into the bloodstream and in the most severe cases can lead to multi-system organ failure and/or death.

In the intensive care unit (ICU), 48% of patients have central venous catheters, and approximately 28,000 ICU patients in the United States of America die each year of central line infections (*7*). A prospective study comparing incidence of central venous catheter bloodstream infection rates found no significant differences among intensive care units from 15 countries (3 Asian Pacific, 7 European, 2 Middle Eastern, 2 South American, and the US) suggesting that it is a worldwide problem (*8*). The CDC reports that an estimated 250,000 cases of central venous catheter infections occur in United States hospitals annually, with an attributable mortality of about 12% to 25% for each infection and a marginal cost of approximately $25,000 (USD) per episode (*1*). Another study found that bloodstream infections prolong hospitalization by a mean of 7 days (*9*).

Associated Issues:

To improve patient outcomes and reduce health care costs, strategies should be implemented to reduce the incidence of central line-related bloodstream infections. Strategies such as appropriate use of hand hygiene; chlorhexidine skin preparation; full-barrier precautions during insertion; avoiding the femoral site for insertion; maintaining a sterile field; specialized nursing teams for catheter maintenance; creating a central venous catheter insertion cart; asking providers daily whether catheters can be removed; and appropriate dressing and maintenance of the insertion site have demonstrated effectiveness (*6, 7, 10*). In addition, studies utilizing catheters treated with chlorhexidine-silver sulfadiazine or catheters treated with minocycline and rifampin, respectively, reduced the incidence of catheter related bloodstream infections (*11, 12*). Bundling or grouping of these effective, evidenced-based practices can result in significantly greater improvement than if the practices are implemented individually (6, 13).

The use of central line catheters for long-term or indefinite vascular access has dramatically increased in recent years in hospital and especially in outpatient settings. These devices are increasingly used for administering antibiotics and chemotherapeutic drugs, for total parenteral nutrition, for providing high-flow access for hemodialysis and plasmapheresis, and for obtaining frequent blood samples. In the intensive care unit, the incidence of infection is often higher than in less acute inpatient or outpatient settings because of the length of time the catheter remains in place, the threat of colonization with hospital acquired organisms, and the increased number of times the catheter is manipulated each

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day (*1*). As a result, attention to reducing the incidence of catheter-associated bloodstream infections has focused almost entirely on patients in intensive care units (*9, 10, 15*). However, the same strategies used to prevent central line infections in the intensive care unit should be applied to the care of central line catheters in less acute inpatient and outpatient settings.

Suggested Actions:

The following strategies should be considered by WHO Member States.

1. Ensure that health care organizations develop central line infection prevention protocols to diminish catheter-related bloodstream infections (*1, 14, 15*).
   a. Require use of a checklist to ensure compliance with evidence-based guidelines for central line insertion (*7, 14, 15*).
   b. Empower nurses to enforce the use of central line checklists to be sure that all the processes related to central line placement are executed for each line placement (*7, 14*).
   c. Create a standardized central line cart that contains all equipment needed to insert central lines (*7, 14, 15*).
   d. Institute a policy that requires nurses to assist with central line insertion and/or form specialized "IV Teams" for central line insertion (*1, 15*).
   e. Use a multi-disciplinary team approach to improving central line care including all stakeholders involved in the process in order to gain cooperation of all parties (*14, 15*).
   f. Engage executive officers in central line care improvement projects in order to facilitate and sustain transformation of the standard of care (*15*).
2. Promote proper hand hygiene when caring for central lines (*1, 7, 10, 14*).
   a. Appropriate timing for hand hygiene includes:
      - Before and after palpating catheter insertion sites (Note: Palpation of the insertion site should not be performed after the application of an antiseptic, unless aseptic technique is maintained) (*14*).
      - Before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter (*14*).
      - When hands are obviously soiled or if contamination is suspected (*14*).
      - Before and after invasive procedures (*14*).
      - Between patients (*14*).
      - Before donning and after removing gloves (*14*).
      - After using the bathroom (*14*).
   b. Prominently place soap/alcohol-based hand hygiene dispensers and equipment such as gloves near hand sanitation equipment (14).
3. Apply maximal barrier precautions in preparation for line insertion (*1, 7, 10, 14*).
   a. Maximal barrier precautions for those assisting in the procedure means (*1, 14*):
      - Strict compliance with hand hygiene and aseptic techniques.
      - Wearing a cap, mask, sterile gown, and sterile gloves. (Note: the cap should cover all hair and the mask should cover the nose and mouth tightly).
   b. Maximal barrier precautions for the patient means (*14*):
      - Covering the patient from head to toe with a sterile drape, with a small opening for the insertion site.
4. Sterilize with chlorhexidine before central line insertion and during dressing changes (*1, 7, 10, 14, 15*).
   a. Mandate the use of chlorhexidine rather than accepting personal provider preference (*15*).
   b. Apply chlorhexidine antiseptic/detergent using the following technique (*14*):
      - Prepare skin with chlorhexidine 2% in 70% isopropyl alcohol.
      - Press chlorhexidine applicator against skin and use a back-and-forth friction scrub for at least 30 seconds.
      - Allow antiseptic to dry completely before puncturing site.
5. Select the optimal site for insertion of the catheter (*1, 10, 14*).
   a. Individualize the decision on which site to choose and make it in the context of the risk of other potential complications for a given patient (*1, 14*).
   b. When possible, avoid femoral catheters which have the highest rate of mechanical and infectious complications (*1*).
   c. Document the rationale for selecting the vessel for insertion (*14*).
   d. Use a central venous catheter with the minimum number of ports or lumens required for management of the patient (*1*).
6. Develop a protocol for maintenance of central lines.
   a. Use proper hand hygiene and aseptic technique (*1, 14*).
   b. Use sterile transparent dressings or sterile gauze to cover the insertion site (*1*).
   c. Do not use topical antibiotic ointments or creams on insertion sites because of their potential to promote fungal infections and antimicrobial resistance (*1*).
   d. Do not submerge the catheter under water (*1*).
   e. Inspect the site daily for signs of infection (*1*).
   f. Replace dressings if they become damp, loosened, or soiled (*1*).
   g. Replace IV administration sets 72 hours after initiation of use. When a fluid that enhances microbial growth is infused (e.g., lipid emulsions and blood products), more frequent changes of administration sets are indicated (*1*).
   h. Designate a port exclusively for parenteral nutrition if a multi-lumen catheter is used (*1*).
   i. Cap all stopcocks when not in use (*1*).
   j. Minimize contamination of access ports by wiping with an appropriate antiseptic before accessing the system and using only sterile access devices (*1*).
   k. Do not routinely replace central lines solely for the purpose of reducing risk of infection (*1*).
   l. If adherence to aseptic technique at time of insertion is not likely (e.g., emergent insertion), replace the central line within 48 hours (*1*).
   m. Document operator, date, and time of catheter insertion and removal, and dressing changes on a standardized form (*1*).
7. Review daily the need for a central line and remove unnecessary lines promptly (*7, 10, 14*).
   a. Include daily review of central line necessity as part of multidisciplinary rounds (*14*).
   b. State the number of days the central line has been inserted during rounds as a reminder of how long the line has been in, e.g., "Today is line day 5" (*14*).
8. Provide education and training for staff on bloodstream infection control practices, including central line site selection, insertion, site assessment, dressing change requirements, documentation requirements, appropriate flushing procedures, tubing replacement, and central catheter removal and/or replacement requirements (*1*).
9. Evaluate the effectiveness of the central line insertion protocol (*14*).
   a. Measure the rate of central line catheter-related

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bloodstream infections (data may be expressed as the number of catheter-associated blood stream infections per 1,000 catheter-days) (*1, 14*).

b. Measure compliance with the central line infection prevention protocol (*14*).

c. Track measures over time to demonstrate improvement (*14*).

d. Provide regular feedback to staff on infection rates (*14*).

Looking Forward:

1. Whenever possible use antimicrobial-coated catheters in adult patients whose catheters are expected to remain in place for more than 5 days (*1, 16*).
2. Consider the use of prophylactic antimicrobial lock solutions in special circumstances (patients with history of recurrent central line catheter-associated infection despite adherence to other recommendations) (*1, 16*).

Applicability:

- Ambulatory Care, Assisted Living, Home Care, Hospital, and Long Term Care.

Opportunities for Patient and Family Involvement:

- Teach patients and families the proper care of the central venous catheter as well as precautions for preventing infection.
- Teach patients and families to recognize signs and symptoms of infection.
- Encourage patients to report changes in their catheter site or any new discomfort (*1*).
- Encourage patients and family members to make sure that doctors and nurses check the line every day for signs of infection.
- Invite patients to ask staff if they have washed their hands prior to treatment, if culturally appropriate.
- Encourage patients and family members to ask questions before a central line is placed.

Potential Barriers:

- Staff competency. • Staff adherence to proper insertion and maintenance of central lines.
- Patient and family competence and adherence.
- Failure to communicate the importance of central line care to staff.
- Failure to provide ongoing teaching as new staff become involved in the process.
- Lack of physician and staff buy-in.

Risks for Unintended Consequences:

- Undiagnosed infection site and systemic bacteremia or sepsis.
- Local skin breakdown, irritation, or infection.
- Potential emergence of resistant pathogens associated with the use of antimicrobial-coated catheters (*16*).

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Other Selected Resources:

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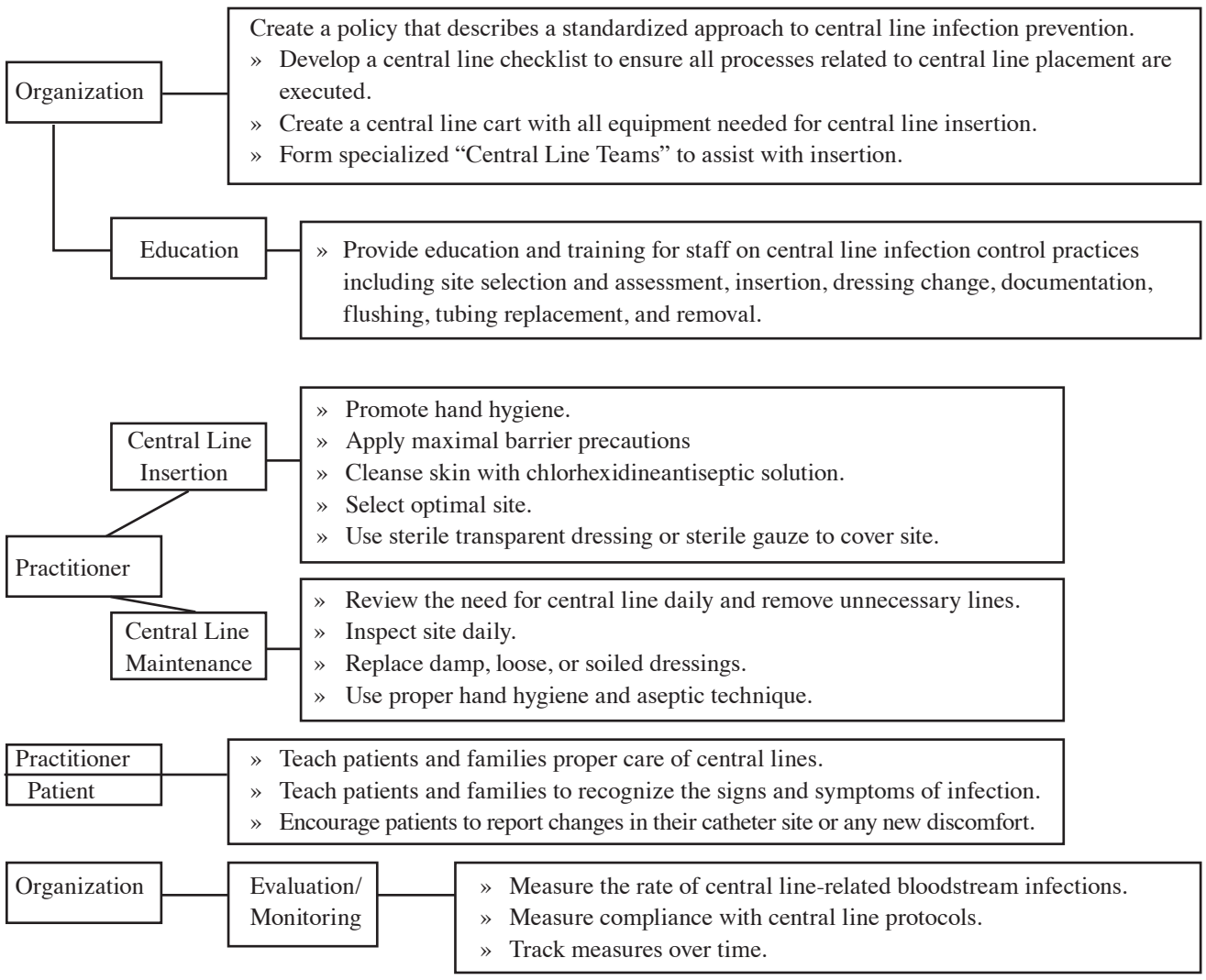
- United Kingdom National Health Service, Christie Hospital NHS Foundation Trust. *Care of your Central Venous Catheter: A guide for patients and their carers. 2007 May:* http://www.christie.nhs.uk/patients/booklets/pdf/central_venous_catheter.pdf

Solution at a Glance
Improved Central Line Care to Prevent Health Care-Associated Infections



NDNQI 2008 Conference: Workforce Engagement In Using Data To Improve Outcome

ANA President Rebecca M. Patton, MSN, RN, CNOR speaking at the NDNQI conference in Orlando, FL

The 2nd annual National Database of Nursing Quality Indicators™ (NDNQI®) data use conference was held in Orlando, Florida on Jan. 30-Feb. 1, 2008. More than 900 attendees at the conference heard distinguished speakers such as: Barry M. Straube, MD, director of the Office of Clinical Standards and Quality and chief medical officer for the Centers for Medicaid and Medicare Services; Mary Naylor, PhD, RN, FAAN, the national program director for the Robert Wood Johnson Foundation program, Interdisciplinary Nursing Quality Research Initiative; Marybeth Farquhar, MSN, RN, CAGS, quality improvement senior advisor for the Agency for Healthcare Research in the center for Delivery, Outcomes and Market; and Nancy Dunton, PhD, Principal Investigator for NDNQI.

Close to 40 podium presentations and more than 65 poster presentations were provided on subjects focused on workforce engagement in using data to improve outcomes.

Educational sessions identified how hospitals use NDNQI reports to improve nursing practices and patient outcomes;

- Described best practices employed to improve RN satisfaction, retention and recruitment,
- Presented tools and techniques used to make the "business case" for quality improvement,
- Recognized national spotlights on public reporting, pay-for-performance, electronic health records and subsequent nursing-sensitive indicator integration;
- Described nurse staffing models and successful staff engagement in improving patient and staff outcomes.

New to the conference were two full-day pre-conference workshops that focused on educating the NDNQI site coordinators, who are the interface between their hospitals and the database. Pre-Conference I assisted coordinators who had been in their NDNQI role less than one year. Educational sessions included describing the roles of the NDNQI site coordinator and RN Survey Coordinator, recognizing how to access and read the NDNQI reports and identifying the differences between the RN Survey instruments. Pre-Conference II focused on providing advanced site coordinator training for the coordinators who wanted a more in-depth understanding of NDNQI data and training on how to use quarterly and RN survey reports for decision making. Topics included: describing the various NDNQI data details to enhance NDNQI data understanding, identifying report fundamentals and recognizing how NDNQI reports can be used for decision making. More than 400 registrants attended the two pre-conference workshops.

Feedback from the pre-conference and conference sessions included, "Pre-Conference offering were great," "Posters were excellent," "Overall—great conference—better than last year," "The three days of the conference were worth it. I can't wait for next year's conference. Highly recommended for nurses dealing with quality and high level decision making stakeholders"; and "This is one of the best nursing conferences I have ever attended. Showing quality improvement outcomes through the use of the NDNQI data was fantastic. Let nursing know what we can do to help NDNQI become our voice for quality in the national arena."

In addition to the pre-conference workshops also new this year was the NDNQI Award for Outstanding Nursing Quality™. The award reflects nursing quality excellence in RN satisfaction, patient outcomes and nurse staffing. An analysis performed by the NDNQI staff involved rank-ordering the hospitals based on the values of all NDNQI indicators. Candidates included general hospitals that submitted data to NDNQI over the past 12 quarters and participated at least once in the RN Survey. Based on the analysis, Poudre Valley Hospital from Ft. Collins, CO. was the inaugural recipient of this award.

Plans are underway for next year's conference, which will be held in Dallas, TX, Jan. 21 to 23, 2009. Save the date and don't miss this exciting annual conference!

Source: American Nurses Association (2008). *CMA Insider, 8* (2), pp. 1-3.

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