2008 will be an exciting year for Nevada and the nursing profession. For the first time Nevada will have a voice in the process of choosing the candidates that will eventually become the next president. The date for this process will occur earlier this year in Nevada, to allow the western states to have a voice in choosing the candidates for the next presidential election.

As nurses we need to have our voice heard on the healthcare issues that affect our profession, families and communities. The candidates have made frequent visits to the communities of this state. They have shared their beliefs and programs related to these issues. Health care reform, safe staffing, patient safety are issues that are paramount to the nursing profession. These are some of the issues that NNA will be following and supporting. Nurses must listen to each of the candidates and elevate their messages concerning these issues, which do they support and how will they implement changes that will enhance the care of the patients we care for.

NNA in collaboration with ANA will be looking at the issues that affect our profession. Nursing needs the strength of the system to continue to provide care to our patients. Become aware of the process; help make decisions that will make a difference for all of us. This is an opportunity to have our voice heard.

No matter where you turn these days, everyone seems to have an opinion on who will be our country’s next President. Soon ANA members will have the opportunity to vote for the candidates believe they will be the strongest advocate for the nursing community while serving in the White House. ANA’s Election 2008 Action Center will be home to the “virtual voting booth,” an online poll that will give voice to the presidential candidate most preferred by nurses.

Member input is a key component of the ANA’s presidential endorsement process. For a two-week period, ANA members will be able to log-in to a secure webpage in order to vote for their preferred presidential candidates. Members will be given one opportunity to cast a vote for their first and second choices for the contenders who should receive ANA’s endorsement. The results of this online poll will then be factored into the endorsement criteria used by ANA’s Presidential Endorsement Task Force and the ANA-PAC Board of Trustees to make a endorsement recommendation to the ANA Board of Directors.

Before casting their votes, members can study each candidate’s health care plans, nursing platforms, and responses to ANA’s 2008 Presidential Candidate Questionnaire on the “Meet the 2008 Presidential Candidates” page on the Election 2008 Action Center.

The “virtual voting booth” will be open to ANA members. Be sure to periodically check the Nursingworld website for ANA’s election dates.

Janet Haebler MSN RN Associate Director, State Government Affairs, ANA (301) 628-5111, Janet.Haebler@ana.org
In This Issue

NNA President’s Message ........................................... 1
ANA’s Virtual Voting Booth ................................. 1
The ANA Unveils Election Action Center ............... 1
State Activities ...................................................... 3-7
Legislation ........................................................ 8-10
ANA News ....................................................... 11-13
ANA and NNA .................................................. 14, 15
Practice Issues ............................................... 16-18
News You Can Use ............................................. 19-25
Membership Application .................................... 26

NNA Mission Statement

GOALS & OBJECTIVES

MISSION
The mission of the Nevada Nurses Association is to advocate for the profession of nursing, representing the collective voices of registered nurses.

GOAL
1. Promote and uphold excellence and integrity for the profession of nursing.
2. Educate and advocate for accessible, affordable, quality health care for clients/consumers.

OBJECTIVES
Sustain our leadership role that actively supports individual nurses in their professional practice.

- Educate nurses about professional practice advocacy.
- Provide a proactive presence in legislative and regulatory activities for health related issues.
- Participate with consumer and health care groups in establishing health care policy.
- Encourage, promote and support political candidates who have demonstrated support of the mission, goals, and objectives of the Nevada Nurses Association.
- Be a strong, proactive presence in working with local, state, and national regulatory agencies involved in health care.
- Collaborate with programs of higher education for nurses to enhance the image and integrity of the profession.
- Promote nursing as a career option for men, women, and minorities targeting the elementary, secondary, and postsecondary educational settings.

Article Guidelines for the RNFORMATION

Nevada Nurses Association welcomes original articles related to nursing for publication in the RNFORMATION.

Format and Submission
Articles should be word-processed as Word documents in 10 or 12-point font, single or double-spaced. There is currently no limit to the length of the article. Include the title of the article and headings if applicable. Author’s name should be placed after the title with credentials, organization and/or employer and contact information. Authors must identify potential conflicts of interest, whether of financial or other nature and identify any commercial affiliation if applicable.

All references should be listed at the end of the article. Pictures in black and white or color are encouraged and may be sent as a jpg. File as an email attachment or on disc. Be sure to spell check and grammar check your article, any website addresses, references or phone numbers. It is recommended you have a colleague review your article before submission.

Prepare the article as a Word document and attach it to an email to nna@nvnurses.org. If you do not have Word, try pasting the text of the article directly into the body of the email. You may also mail the article on disc in a Word document to RNFORMATION, Nevada Nurses Association, P.O. Box 34660, Reno, NV 89533.

Nevada Nurses Association does not support strikebreaking nurses and does not accept articles on behalf of such. Articles appearing in this publication express the opinion of the staff, board or membership of NNA. Authors are not required to be members of NNA.

If you have any questions call the NNA office at 775 747-2333 or email nna@nvnurses.org.

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MD
NNA 2007 Raffle winners—

Congratulation

Mary Lou Minor, McDermitt, NV  First prize $1000
Mildred Glaw, Sparks   Second Prize $500
Doris Long, Socorro, New Mexico  Third Prize $500
Janet Bryant, Gardnerville, NV  $160 Software Gift
Annie Hall  Certificate
Ermestine Ellis    $350 Wine Basket
Regina McFerrin    Custom Designed gem stone Jewelry

and a special thanks
to the great sellers!

Mary Lou Minor—First Prize Raffle Winner

On our request our big raffle winner has provided a little insight of her background and her home town. Enjoy her comments.

McDermitt is a small western town situated at the border between Nevada and Oregon. It’s an easy 70 mile drive from Winnemucca, which sits at the cross-roads of Interstate 80 and U.S. Highway 95. McDermitt can also be accessed easily from the north via Jordan Valley, in Oregon 100 miles away; the Idaho border is 120 miles north of McDermitt.

I came to McDermitt as a bride with my new earned R.N. There certainly were no facilities around here to work. McDermitt has approx 200 residents with the Pauite/Shoshone reservation 5 mile south (approx. 500 residents). In the early 60’s the Indian Health Service came to this reservation once a month to hold clinic. I was asked to work that one day with the Drs. that came here from Schurz, NV.

Then in 1966 I went to work for the Humboldt County School District as the school nurse in McDermitt. At that time the school was consolidated with both Indian and caucasian students with approx 300 students in grades K thru 12th. I stayed there 7 years.

During the three years in between I attended a Rural Nurse Practitioner Program. After completion I went back to the School District as the County School Nurse traveling the county and I had 10 schools under my responsibilities; driving about 10,000 miles per year. Seven of these schools were very rural with few students (from 5 to 40) with the three schools in Winnemucca having the largest number of children. I spent two days a week in Winnemucca. At that time the district had a total of 1500 students.

I retired in 2001 after 32 years. Many changes had come about during those years. Student population increased to 4500 students at the most. At one time there were four school nurse's providing care. Now all schools have aides with one RN to over-seeing all health care.

Thank you all, Mary Lou Minor
The National Black Nurses Association (NBNA) elected Debra A. Toney, PhD, RN as its 10th National President. Dr. Toney is honored to have been elected to represent Black nurses in this country. She looks forward to the opportunity to address critical health care issues impacting the Black community and in defining the needs of Black nurses across the nation.

Dr. Toney currently serves as the Chief Administrative Officer of Rainbow Medical Centers in Las Vegas, Nevada, and has responsibility for six primary care/urgent care centers and an outpatient diagnostic center. Under Dr. Toney’s leadership, Rainbow Medical Centers became the only independently owned, family practice/urgent care centers to become JCAHO accredited in the State of Nevada. Dr. Toney is also the President/Owner of TLC Health Care Services, a licensed home health care agency specializing in private duty nursing and supportive care services.

She is the founding President of the Southern Nevada Black Nurses Association and enjoys membership in the American Nurses Association, Nevada Nurses Association, National Coalition of Ethnic Minority Nurse Associations, American College of Healthcare Executives, Sigma Theta Tau International and the Medical Group Management Association. She is the chairperson of the State of Nevada Office of Minority Health Advisory Committee and a member of the Board of Directors for the Nevada State Board of Health. She is serving on the Nominating Group of the U.S. Food and Drug Administration. Dr. Toney is a Robert Wood Johnson Executive Nurse Fellow.

Northern Nevada Nurses of Achievement Awards

Recognizing the need to shine a spotlight on a profession founded over 150 years ago by nurse Florence Nightingale, the Northern Nevada Nurses of Achievement Committee was formed in 1999. The goal of this committee of dedicated nurses was to honor their colleagues and the profession of nursing by recognizing outstanding individuals by nurse Florence Nightingale, the Northern Nevada Nurses of Achievement Committee as its 10th National President. Dr. Toney is honored to have been elected to represent Black nurses in this country. She looks forward to the opportunity to address critical health care issues impacting the Black community and in defining the needs of Black nurses across the nation.

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Nursesofachievement.com/
of Achievement web site—Submission deadline Feb 1, 2008 http://www. ticket(s), please call (775) 328-1497

In promoting the profession of nursing, the Northern Nevada Nurses of Achievement Committee has raised money to support six nursing scholarships a year, across Northern Nevada. The 2008 Northern Nevada Nurses of Achievement Awards Dinner will be held: Friday, May 9, 2008 Harrah's Reno—Convention Center 219 N. Center St. Reno, NV 89501 (775) 788-2929 Tickets are $38 per person and will be sold from April 1 - May 2. To order your ticket(s), please call (775) 328-1497 Nominations for the following categories may be made online at Nurses of Achievement web site—Submission deadline Feb 1, 2008 http://www. nursesofachievement.com/

Acute Care—Critical Care
Acute Care—Medical/Surgical/Maternal Child
Advanced Practice
Community Health
Education
Innovation
Leadership,
Licensed Practical Nursing
Lifetime Achievement
Long-term Care/Rehabilitation
Office/Outpatient
Patient Advocacy
Rural Health

Journey to Magnet Status

University Medical Center (UMC) is journeying to becoming the first hospital in Nevada to achieve Magnet Recognition status. The Magnet Recognition Program® was developed by the American Nurses Credentialing Center, a subsidiary of the American Nurses Association, which recognizes health care organizations that provide the very best in nursing care.

The Magnet designation has 14 special ‘Magnet Forces’, emphasizing various domains of nursing. Magnet Force 12 focuses on the Professional Image of Nursing. The Magnet Force 12 Committee at UMC conducted a research study to determine which nurses’ uniform most represents professionalism to the non-nursing public. The Committee designed their research to replicate a study done at the prestigious Cleveland Clinic in 1999.

The study’s participants were asked to vote for their preference of nurses’ uniforms from a poster board displaying the same nurse dressed in 9 different uniform options. Efforts were made to make the pictures as similar as possible except for the uniform itself. Data were collected September 17-21, 2007.

A total of 512 valid uniform preference votes were obtained from non-nursing health care workers (181), visitors (122), and adult (188) and pediatric patients (21). The uniform choices in this study included: Curious George top/blue pants, white top/navy pants, orange & green flowered top/orange pants, white top/white pants, brown & turquoise squared pattern top/brown pants, navy top/navy pants, Sesame Street top/neon green pants, spring flower top/red pants, and burgundy top/burgundy pants.

The study’s results are now available. The number one preference from all groups of all ages was the traditional white uniform (white top and white pants). The choice of all white uniform is consistent with all other similar studies found in the nursing literature to represent perceived professionalism. Burgundy and Navy ranked second and third respectively.

The Magnet Force 12 Committee is currently discussing the results and the implications for possible changes to increase the professional image of nursing at UMC. Their final recommendations to the nursing self-governance councils and nursing administration are still pending.

Results: Participants’ Choices

(N = 512)

<table>
<thead>
<tr>
<th>Uniform Preference</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<th>E</th>
<th>F</th>
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<tbody>
<tr>
<td>A = Curious George Top/</td>
<td>29</td>
<td>59</td>
<td>30</td>
<td>167</td>
<td>26</td>
<td>60</td>
<td>41</td>
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<td>Blue Pants</td>
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<td>B = White Top/Navy Pants</td>
<td>115</td>
<td>5.7</td>
<td>11.5</td>
<td>30.7</td>
<td>5.1</td>
<td>11.7</td>
<td>8.2</td>
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<td>C = Orange &amp; Green</td>
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<td>Flowered Pattern Top/</td>
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EDITORS NOTE: Harrah for the WHITE Uniform!
In the early 1950s, Nevada was the only state in the Union that did not have a nursing education program. In 1954, UNR sought assistance from the U.S. Public Health Service to initiate a survey on nursing needs and resources. At the time of the survey, Nevada had 637 full-time nurses and the survey indicated “a deficit of nursing personnel” in Nevada. During the same time period, Reno resident Arthur Orvis experienced a brief hospitalization and noticed that there were no student nurses.

In 1955, the UNR President, University Board of Regents and the Nevada State Legislature authorized and established a school of nursing on the University of Nevada, Reno campus. With the backing and philanthropy of many concerned citizens, including Arthur Orvis and his wife Mae Orvis, the Orvis School of Nursing was founded. In a letter to University President Minard W. Stout dated December 15, 1955, Arthur Orvis said, “As mentioned to you on several occasions, I desire to give $100,000 to the University of Nevada for the establishment of a department to be known as the ‘Orvis School of Nursing.’ This is a free will offering with no strings attached.”

The University proceeded quickly in finding the personnel who could develop the nursing program, and in 1956, the first Dean of the Orvis School of Nursing, Dr. Doris Yingling, began work to develop the school. The following year, 1957, the Orvis School of Nursing opened as the first nursing education program in the State of Nevada with twelve students and five nursing faculty, pioneering baccalaureate-level nursing education in our State.

With the beginning of the Fall 2007 academic semester, the Orvis School of Nursing began celebrating its 50th year of providing quality nursing education to the citizens of Nevada. As the leader in nursing education in Nevada, the Orvis School of Nursing was the first to:

• Offer a four-year baccalaureate degree nursing program
• Offer a totally online RN to BSN program
• Offer a fast-track BSN program for second-degree students
• Offer a master’s degree program
• Offer a Master of Science in Nursing/Master of Public Health combined degree program
• Serve as a sponsor and mentor for the nursing programs established at UNLV and Nevada State College
• Open the only nurse-managed clinic in Nevada

The times and the look of the uniform may have changed, but after fifty years the Orvis School of Nursing continues to provide quality nursing education for the state of Nevada and beyond. The school is now housed in the University of Nevada School of Medicine, and the Orvis School of Nursing has had several international collaborations, including working with nursing faculty in Russia and, most recently, hosting students from the University of Hiroshima, Japan this past summer. As we begin our next 50 years, the Orvis School of Nursing looks toward the progressive use of simulation technology, development of futuristic programs and the conduct of cutting-edge nursing research to meet the nursing workforce needs of Nevada and beyond.

(The Orvis School of Nursing includes the Orvis Nursing Clinic, a nurse-managed clinic that provides health care to the un- and under-insured in the Reno.)
Las Vegas District Three— CONGRATULATIONS!!!

District 3 has been busy this fall. We had a good participation by the membership of NNA, the Black Nurses Association, the Philippine Nurses Association, and the American Nurses Association, at the Cultural workshop for NNA, UNLV. The attendees actively participated in the main sessions as well as the break-out sessions. We learned from the nurses from the Philippines, the issues around being accepted by American born nurses and the expectations they have about practicing nursing in the United States. There were nurses from India that have started working at the St. Rose hospitals in Las Vegas. They praised their mentor from St. Rose and the program that was developed by St. Rose to assist them in accimating to life in a new country as well as nursing care in the United States.

Tikva Butler, APN—a member of the APN Special interest group went on a medical mission to the Dominican States. There were nurses from India that have started working at the St. Rose hospitals in Las Vegas. They praised their mentor from St. Rose and the program that was developed by St. Rose to assist them in accimating to life in a new country as well as nursing care in the United States.

Lisa Carver, MSN RN and Ann Diaz, MSN RN both Ph.D candidates at UNLV are the first recipients of the Yaffa Dahen Dissertation Scholarship. Dr. Yaffa Dahen passed away this past summer and her family decided to establish a scholarship fund in her memory. Dr. Dahen was a member of the year at UNLV. I had the good fortune of meeting Yaffa about 20 years ago. Although she was a registered nurse in her country of Israel, she decided to get her degree in nursing from the United States. She worked tirelessly, eventually obtaining a Ph.D in healthcare administration. She was CEO of the Mount Charleston Hotel at the time of her death and was developing a wellness spa. She leaves a husband David and two lovely daughters Michelle and Shana.

Debra Toney, RN, Ph.D, a member of the Nevada Chapter of the National Association of Black Nurses has been elected President of the National Association of Black Nurses. This is quite an achievement as well as an honor. Dr. Toney is a Robert Wood Johnson Fellow and is CEO of the Rainbow Medical Clinics Inc. The National Black Nurses Association will have their National Convention here in Las Vegas at Mandalay Bay, August 4-8 2008.

In October, Rosemary Witt arranged for a representative from Social Security to give a presentation about retirement rules and regulations with Social Security. This program was held at the new Rawson-Neal Psychiatric Hospital. Many attendees are employed where pension plans are in place for retirement. The representative discussed how those on pension plans may collect Social Security and how to boost the amount of Social Security they may receive. Nancy Mengel organized an NNA Christmas project at Opportunity Village. Festival of Holiday Lights on December 4th. There were approximately 75 volunteers with NNA. An impressive show! Many of the faculty from UNLV attended, including Dean Yuhos. The volunteers helped with snack bar, the train, the carousel, the gift shop and other areas. Everyone had a good time and wants to volunteer next year. They most impressive group were all of the nursing students that volunteered—at least 50. The group of students were young, multi-ethnic, including many males. They were enthusiastic and did a wonderful job. Thank you to all of the volunteers, both nurses and students. Most nurses and students either worked or had classes that day. The volunteer hours were from 5pm-10pm. No one complained in spite of this being a Tuesday evening and most volunteers had classes, clinicals, or work the next morning.

Martha Drehobycz
GIRL SCOUT NURSING DAY 2008
Sierra Nevada Council of the Girl Scouts

The Paths of Nursing!

We made an impact on young girls in Northern Nevada and California!!! Thank you to all of the volunteers. Last year’s event was the “largest and most successful” of the Council’s activities. Therefore, the council would like to host Nursing Day again. This year’s theme is different. Last year we looked at skills of a nurse. This year, we thought to accent the diversity of practice in nursing. All of you can help share the joy you have for your area of practice by signing up and volunteering as a “Point Person” or a “Team Member” for the specialty. Please contribute your ideas on how to make it a fun, interactive, learning day for the young women of our area. Yes, we can repeat some of those fun things from last year—like dressing up in OR gowns!

Best regards,
Betty & Bernie

THE DETAILS

Date: Saturday, May 3rd, to “kick-off” Nurses Week
Location: Renown Regional Medical Center—Mack auditorium & classrooms
Time: 8:30am–1pm
Lunch offered 11:30-12:30 in Cafeteria Classroom
Council Level Activity: Brownie, Junior, Cadette, Senior
Fee: $5.00 per girl—$10.00 per girl after April 20 (Please note: this is customary and low priced to cover the council’s cost of the patch; there are always scholarships available, so we do not turn away any scout who cannot afford to pay!).

Coordinators:
Anna Thornley—Girl Scouts Program Specialist—athornley@gssn.org
Bernadette “Bernie” Longo, PhD, RN
Girl Scouts & University of Nevada Reno—longo@unr.edu
Betty Razor, RN
Nevada Nurses Association—etbetty@sbcglobal.net
Representative of Renown Regional Medical Center (to be determined)
Student Nurse Representative from Orvis School of Nursing (to be determined)

Sponsors:
Renown Regional Medical Center
The Nevada Nurses Association
The Orvis School of Nursing at the University of Nevada—Reno

Program Activities:
Check-in at Mack Auditorium. Welcome breakfast bars. Give “Passport” for visiting stations & bag. Volunteers at stations will stamp each girls Passport. Small groups/troops of Girl Scouts (6-8 girls) will rotate through stations with various nursing themes as they desire. Lunch will be provided—available from 11:30-12:30. Wrap-up group activity at 1pm – raffle! Check-out to receive patch.

Volunteers needed: ~ 40 RNs or nursing students
2 Cadet or Senior Girl Scout volunteers

Volunteers: Dress as you nurse (scrubs, lab coat, etc), Name badge says first name and what you do, made up by Girl Scouts (Anna will make, so prior commitment to participate is needed!)

Station where we need volunteers:

Contact: Betty Razor: etbetty@sbcglobal.net

Special Seminar in April

District One of Nevada Nurses Association Presents
Addiction: Causes, Cures and Cost to the Community Airport Plaza Hotel, Reno Nevada Saturday, April 19, 2008

Our topic for the day will involve Addiction and our plenary speaker with be Dr. Melissa Piascik of the Department of Psychiatry University of Nevada School of Medicine.

This seminar will examine the biological basis for addictions, and the bio-behavioral means of their modification. Workshops and roundtables will explore the stigma of addiction and the special problems posed by socially acceptable obsessions such as over-eating.

Every nurse who deals with a wide cross section of patients, will encounter the destruction addictive behavior that can complicate recovery, destroy social support networks, and guarantee relapse.

The costs imposed upon Nevadans by addiction are astronomical. Legal drugs used illegally, legal agents such as alcohol and tobacco used to excess, illicit and designer drugs... all can and will greatly influence the ways in which nurses’ care for their patients.

Spend a day exploring this vital field of information and collect a day's worth of CEU's at a reasonable price.

Contact: Jeannette McHugh jmaphel@earthlink.net
Nevada Legislative Interim Committee on Health Care

Nevada Nurses have a responsibility to be aware of the legislative activities that impact our practice and patient care. NNA will continue to monitor the progress of the interim Legislative Committee on Health Care (LCHC). The committee meets monthly till 2009 and is currently chaired by Assemblywomen Sheila Leslie. The public is encouraged to attend or view the hearing on line. All meetings are conveniently held at either the legislative building in Carson City or the Grant Sawyer State Office Building in Las Vegas. They are simulcast by a video conferencing technique to the alternate site. This allows for testimony or questions from both locations and total access to the handout outs on the agenda.

The meetings in 2008 are currently scheduled through May:
- Tuesday, February 12, 2008
- Thursday, March 6, 2008
- Thursday, April 10, 2008
- Tuesday, May 6, 2008

History and Responsibilities of the LCHC

The primary responsibilities of the LCHC are established pursuant to the Nevada Revised Statutes (NRS) 439B.220 through 439B.240. These responsibilities include reviewing and evaluating the quality and effectiveness of programs for the prevention of illness, reviewing and approving the health care delivery system, public health preparation and other issues including health care cost containment, access to care for the uninsured, Medicaid, managed care, the rural health delivery system, public health preparation and other issues.

In addition, members strive to avoid duplication of services and achieve the most efficient use of all available resources. The LCHC also may review health insurance issues, and may examine hospital-related issues, medical malpractice issues, and the health education system. Additionally, pursuant to NRS 439B.225, the LCHC is responsible for reviewing certain health care regulations. The LCHC was established in 1987 to address escalating health care cost; including health care cost containment, access to care for the uninsured, Medicaid, managed care, the rural health delivery system, public health preparation and other issues.

As a result of the 2007 legislative session some other issues have been required: monitor child welfare services that fail to comply with the law, evaluating the health care needs of children in Nevada and set up the Nevada Academy of Health.

With the passage of Bill 342 the LCHC is required to develop a comprehensive plan concerning the provisions of health care in the state.

You may access all committee agendas at: www.leg.state.nv.us on the right hand of page is “Calendar of Meetings: and “Listen to Live Meetings.”

ADOC (Advance Directive Online Completion)

COMING FEBRUARY 26, 2008
Building Healthy Nevada

Healthcare providers need to know what a patient wishes—especially at end of life. In order to let their healthcare providers know, patients may choose to fill out an Advance Directive (AD) stating their medical wishes. In fact, federal law requires that hospitals ask patients about an AD upon admission and offer them the opportunity to complete one. Despite the federal law, unfortunately, only about 20% of Nevadans have completed one. To address this problem, Nevada lawmakers passed legislation during the 2007 session better enabling the Nevada Center for Ethics & Health Policy at the University of Nevada Reno in conjunction with the Nevada Secretary of State’s Office to create a two step solution.

Step One: For individuals who have not yet completed their AD, ADOC will be available. ADOC (Advance Directive Online Completion) is a guided form to assist individuals in completing their Advance Directive (AD). The online form is user friendly and provides answers to frequently asked questions. Once the AD is completed online, it must be printed out and witnessed or notarized.

Step Two: The AD can then be sent to be scanned and placed into a secure online repository housed at the Secretary of State’s Office. Once online, the AD can be viewed by the individual or by a registered, healthcare provider. Registration will be available to all hospitals and healthcare facilities. Individual providers (such as a APN or physician’s office) can registered, if needed. If an individual patient chooses not to file their AD online, they can file a “locator.” This will advise the healthcare provider where their AD is located for relatives to retrieve.

On the Horizon: In several other states who have developed online methods for completing and filing an AD for online viewing, the rates of AD completion increased. This is good news for nurses who are advocates for their patient’s wishes.

The two step solution will be rolled out on February 26, 2008. If you have any questions about how this may affect you or your patients, please feel free to contact the Nevada Center for Ethics & Health Policy (775)327-2309 or email ethics@unr.edu.

Rabbi ElizaBeth Beyer, R.N., M.S., J.D., Attorney at Law
Nevada Center for Ethics & Health Policy
University of Nevada, Reno MS 339
Reno, NV 89557
775-322-5542
rebeyer@unr.edu
The Nevada State Board of Nursing’s mission is to protect the public’s health, safety and welfare through effective regulation. It is a governmental agency established by Nevada law with its primary goal to protect the public from unsafe practice by nurses.

The Board’s current functions include:
- Administration
- Establish minimum practice standards
- Develop and adopt regulations
- Appoint advisory committees to get direct nursing input
- Publish, distribute and provide education on the Nurse Practice Act
- Collaborate with consumers, individuals, groups and organizations
- Provide education to increase public awareness and understanding of the Board’s role and purpose
- Licensure, Certification and Education
- Approve schools of nursing and nursing assistant training programs
- Adopt exams for licensing/certification
- Issue certifications
- License registered and practical nurses
- Certify advanced practitioners of nursing, certified registered nurse anesthetists, and emergency medical service/registered nurse
- Approve education/training programs for ongoing competency
- Discipline and Investigations
- Investigate complaints against nurses and nursing assistants
- Conduct disciplinary proceedings
- Administer remediation and rehabilitation programs, including:
  - Monitoring nurses and nursing assistants who are on disciplinary probation
  - Administering alternative program for nurses recovering from chemical dependency.

Nevada State Board members:
- Helen Vos, MS, RN, President, RN Member; Betty McKay, LPN, Secretary, LPN Member; Doreen Begley, MS, RN, NR Member; Belen Gabato, MS, RN, NR Member; Mary Ann Lambert, MSN, RN, NR Member; Carrie McMurray, CAN, CNA; Sandy Peltyn, Consumer Member

Executive Director Debra Scott, MSN, RN, APN
Contact Information for the Nevada State Board of Nursing, 5011 Meadowood Mall Way #300, Reno, NV 89502-6547; Phone: 1-888-590-6726; email info@nsbn.state.nv.us; Web site: www.nursingboard.state.nv.us

Legislation

What The Nevada State Board Of Nursing Does And Does Not Do

The role of the Board is often confused with the role of nursing associations. It is also confused with the role of other governmental bodies. We hope this brief list will help clear up some of the confusion and help you direct your efforts where they will be most effective.

THE BOARD IS a governmental body responsible for protecting the public.

THE BOARD IS NOT a membership organization for nurses or CNAs. Such organizations are responsible for the certification and profession of nursing and setting standards of practice.

THE BOARD IS responsible for enforcing the laws, regulations, and practice decisions that regulate the practice of nursing, the Nevada Nurse Practice Act. It is on our website or available for purchase.

THE BOARD CANNOT independently change the law (statutes). Only the Nevada State Legislature can make changes. For a list of state senators and assemblymen, visit the legislature’s website at www.leg.state.nv.us, or call the legislature at 1-800-992-0973.

THE BOARD IS responsible for adopting regulations which establish minimum legal standards for safe practice and clarify or explain statutes.

THE BOARD DOES NOT make or change regulations in secret. It is a public process that includes initial research and discussion by a Board advisory committee, Board review, a public workshop, a public hearing, a review of the proposed regulations by the Legislative Counsel Bureau, and approval by the Legislative Committee on Health Care and the Legislative Commission.

THE BOARD REGULATES the scope of nursing practice as defined in law of all registered nurses, licensed practical nurses, advanced practice nurses, certified registered nurse anesthetists, and certified nursing assistants.

THE BOARD DOES NOT REGULATE conditions of employment, such as hiring and firing, shift assignment, staffing levels, or discipline imposed by an employer.

THE BOARD REGULATES the practice of licensed nurses and certified nursing assistants in all practice settings.

THE BOARD DOES NOT REGULATE hospitals, nursing homes, homecare organizations, nor any other health care facility which may employ licensed nurses or certified nursing assistants. The state’s Board of Health has jurisdiction over health care facilities, through its Bureau of Licensure and Certification. If you wish to file a complaint against a health facility, call the bureau at 775-687-4475 (Carson City) or 702-486-6515 (Las Vegas).
# Nursing Programs Approved by the Nevada State Board of Nursing

The Nevada State Board of Nursing has approved the following schools to conduct all portions of their nursing programs in Nevada. (Links to each of these schools are on the home page of the Board's website.)

<table>
<thead>
<tr>
<th>University of Nevada, Reno</th>
<th>Truckee Meadows Community College</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orvis School of Nursing</td>
<td>Nursing Program</td>
</tr>
<tr>
<td>College of Human &amp; Community Sciences</td>
<td></td>
</tr>
<tr>
<td>Reno, Nevada 89557-0052</td>
<td>7000 Dandini Boulevard RDMT 417</td>
</tr>
<tr>
<td>775-784-6844</td>
<td>Reno, Nevada 89512</td>
</tr>
<tr>
<td></td>
<td>775-675-7115</td>
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</tbody>
</table>

**Post-Masters Certificate—Family Nurse Practitioner (FNP)**

**Post-Masters Certificate—Clinical Nurse Specialist (CNS)**

**Master of Science in Nursing (MSN Degree)**

**Bachelor of Science in Nursing (BSN Degree)**

**RN-to-BSN Degree Completion**

<table>
<thead>
<tr>
<th>University of Nevada, Las Vegas</th>
<th>Western Nevada College</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Nursing</td>
<td>Allied Health Programs</td>
</tr>
<tr>
<td>4505 Maryland Parkway</td>
<td>2201 West College Parkway</td>
</tr>
<tr>
<td>Las Vegas, Nevada 89154</td>
<td>Carson City, Nevada 89701</td>
</tr>
<tr>
<td>702-895-3360</td>
<td>775-445-3205</td>
</tr>
<tr>
<td>PhD in Nursing</td>
<td>Associate of Applied Science in Nursing (ADN Degree)</td>
</tr>
<tr>
<td>Master of Science in Nursing (MSN Degree)</td>
<td>Certicate in Practical Nursing</td>
</tr>
<tr>
<td>Bachelor of Science in Nursing (BSN Degree)</td>
<td>RN Refresher Course</td>
</tr>
<tr>
<td>RN-to-BSN Degree Completion</td>
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<table>
<thead>
<tr>
<th>College of Southern Nevada</th>
<th>Great Basin College</th>
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<tbody>
<tr>
<td>Health Science Center, W1A</td>
<td>1500 College Parkway</td>
</tr>
<tr>
<td>6375 West Charleston Boulevard</td>
<td>Elko, Nevada 89801</td>
</tr>
<tr>
<td>Las Vegas, Nevada 89146</td>
<td>775-753-2735</td>
</tr>
<tr>
<td>702-651-5684</td>
<td>Associate of Applied Science in Nursing (ADN Degree)</td>
</tr>
<tr>
<td>RN Program</td>
<td>RN to BSN Degree</td>
</tr>
<tr>
<td>LPN Program</td>
<td></td>
</tr>
<tr>
<td>Associate of Applied Science in Nursing (ADN Degree)</td>
<td>Certificate in Practical Nursing</td>
</tr>
<tr>
<td>RN Refresher Course</td>
<td></td>
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<tr>
<th>Provisional Approval Only*</th>
<th>Provisional Approval Only*</th>
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<tbody>
<tr>
<td>Nevada State College</td>
<td>Touro University</td>
</tr>
<tr>
<td>Nursing Program</td>
<td>School of Nursing</td>
</tr>
<tr>
<td>1125 Nevada State Drive</td>
<td>874 American Pacific Drive</td>
</tr>
<tr>
<td>Henderson, NV 89015</td>
<td>Henderson, NV 89014</td>
</tr>
<tr>
<td>702-992-2000</td>
<td>702-777-8687</td>
</tr>
<tr>
<td>Bachelor of Science in Nursing (BSN Degree)</td>
<td>Entry Level Master's of Science in Nursing (Confer BSN and MSN)</td>
</tr>
<tr>
<td>RN-to-BSN Degree Completion</td>
<td>RN—Master's of Science in Nursing</td>
</tr>
<tr>
<td>BSN—Master's of Science in Nursing</td>
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<tr>
<th>Provisional Approval Only*</th>
<th>Provisional Approval Only*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apollo College</td>
<td>University of Southern Nevada</td>
</tr>
<tr>
<td>Nursing Program</td>
<td>11 Sunset Way</td>
</tr>
<tr>
<td>5740 S. Eastern Ave., Ste. 140</td>
<td>Henderson, NV 89014-2333</td>
</tr>
<tr>
<td>Las Vegas, NV 89119</td>
<td>702-900-4433</td>
</tr>
<tr>
<td>702-688-4300</td>
<td>Bachelor of Science in Nursing (BSN Degree)</td>
</tr>
<tr>
<td><a href="mailto:tecarle@apollo.edu">tecarle@apollo.edu</a></td>
<td></td>
</tr>
<tr>
<td>Associate of Applied Science in Nursing</td>
<td></td>
</tr>
</tbody>
</table>

The Board has approved the following schools to conduct only the clinical portion of their programs in Nevada.

<table>
<thead>
<tr>
<th>California State University, Dominguez Hills</th>
<th>Mojave Community College</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 East Victoria St.</td>
<td>1971 Jagersen Avenue</td>
</tr>
<tr>
<td>Carson, CA 90747</td>
<td>Kingman, Arizona 86401</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Dixie State College of Utah</th>
<th>Feather River Community College</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health Sciences</td>
<td>P.O. Box P</td>
</tr>
<tr>
<td>Nursing Program</td>
<td>Quincy, CA 95971</td>
</tr>
<tr>
<td>225 South 700 East</td>
<td></td>
</tr>
<tr>
<td>St. George, UT 84730</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lassen Community College</th>
<th>University of Phoenix</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 3000</td>
<td>4615 E. Elwood St.</td>
</tr>
<tr>
<td>Susanville, CA 96130</td>
<td>Phoenix, AZ 85040</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Graceland University</th>
<th>University of St. Francis</th>
</tr>
</thead>
<tbody>
<tr>
<td>School of Nursing</td>
<td>College of Nursing and Allied Health</td>
</tr>
<tr>
<td>1401 West Truman Rd.</td>
<td>290 N. Springfield Avenue</td>
</tr>
<tr>
<td>Independence, MO 64050-3434</td>
<td>Joliet, IL 60536</td>
</tr>
<tr>
<td></td>
<td>1-800-605-6637</td>
</tr>
</tbody>
</table>

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*Provisional Approval Only* indicates programs that are currently approved for provisional status.
Why Should Nurses Get Certified?

ANCC 2007
©2007 American Nurses Credentialing Center

Certification offers extensive advantages throughout the healthcare system—benefiting patients and their families, nurses and their colleagues, and the medical practices and facilities that employ these certified professionals. It is, quite simply, an asset to the entire nursing field.

Certified nurses meet strong professional development requirements. By keeping abreast of the latest developments in healthcare and maintaining continuing education, certified nurses not only maintain their competence to practice, but also boost their professional self-confidence.

Nurses who have made continuing professional development a priority assure the public and employers that they have the knowledge, skills, and experience to effectively and safely deliver top-notch care. In a survey by the American Board of Nursing Specialties (ABNS) [1], nurse managers noted that certification validates specialized knowledge, indicates a level of clinical competence, and enhances professional credibility.

Even more noteworthy, nurse certification has been linked to better patient outcomes, according to the American Association of Critical-Care Nurses (AACN), [2] which found that certification is tied to a reduction in medical errors, among other benefits.

Certified nurses are in the greatest demand and command the highest salaries. Nurse managers surveyed by ABNS overwhelmingly prefer to hire certified nurses because certification attests to an individual's proven knowledge base and documented experience in a given specialty. In fact, 90% said they clearly prefer to hire certified nurses.

Further, certification opens doors to higher-paying positions. Nurses certified in a specialty area earn an average of more than $9000 annually than their counterparts who aren't certified.

While more, nurses report that certification increases their job satisfaction and confidence.[2]

ANCC certification exams are a fair and accurate measure of real-world competency. Thanks to an extensive test-development process, ANCC's certification exams are a true gauge of a nurse's ability to provide excellent care.

It all starts with highly qualified, certified nurses who serve on Content Expert Panels representing their specialty area. Individuals are chosen by ANCC to serve on these panels based on their education, experience, and comprehensive knowledge of their specialty. Using this expert knowledge -- along with standards from the American Nurses Association Congress of Nursing Practice and Economics, plus training from ANCC—the expert panels conduct role delineation studies to analyze the professional skills and abilities required within a specific certification type. The panel members then develop test content outlines for the exams.

Next, a separate group of expert nurses write certification exam questions (items), combining their real-world experience with special ANCC training. These test items are then reviewed by ANCC staff and pilot-tested to ensure validity and quality.

Finally, ANCC staff, in cooperation with the appropriate expert panel, assembles the actual exams. An ANCC measurement professional guides the entire process to be certain that all exams are psychometrically sound and legally defensible.

To further ensure the relevance of ANCC certification exams, they are all continually refined and updated to follow the latest scope and standards of practice and role delineation studies (job analyses). ANCC also subjects these exams to outside scrutiny, obtaining accreditation by two different national organizations: the American Board of Nursing Specialties (ABNS) and the National Commission for Certifying Agencies (NCCA) of the National Organization for Competency Assurance.

ANCC certification is accepted by governing boards. ANCC certification is valued throughout the world by national and local agencies, including recognition by all state boards of nursing and the U.S. military. In many states, certification is a requirement for licensure for certain nursing specialties. In addition, the Centers for Medicare & Medicaid Services (CMS) as well as all major third-party reimbursers accept ANCC certification for billing purposes.

Certification contributes to a nurse's professional growth, patient care, personal pride, and paycheck. It is a requirement for certain areas of nursing practice, and a tremendous asset for all others. Take the first step towards bettering your professional future by applying for nursing certification.

American Nurses Credentialing Center (ANCC)

The American Nurses Credentialing Center’s (ANCC) internationally renowned credentialing programs certify nurses in specialty practice areas, recognize healthcare organizations for nursing excellence through the Magnet Recognition Program®, and accredit providers of continuing nursing education. In addition, ANCC offers an array of informational and educational services and products to support its core credentialing programs.

ANCC is passionate about helping nurses on their journey to nursing excellence. Visit ANCC’s web site at www.nursecredentialing.org

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association (ANA).

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ANCC is passionate about helping nurses on their journey to nursing excellence. Visit ANCC’s web site at www.nursecredentialing.org

The American Nurses Credentialing Center (ANCC) is a subsidiary of the American Nurses Association (ANA).

References


I understand that many CMAs have been approached by the Office of the National Nurse (ONN) Campaign. ANA, along with other nursing and public health organizations have developed the following letter on the issue, endorsed by the ANA Board of Directors and released today. The letter articulates signer’s shared concerns about the national nurse proposal and reflects our strong desire to address the very real issues facing nursing and public health. We are hopeful that the letter will provide added perspective on the issue for individuals or organizations considering the merits of the national nurse proposal. The full list of signers is included at the end of this letter.

ANA has held concerns about the practicality and efficacy of the proposed creation of an office of the national nurse since the ONN initiative’s inception in 2005. Although the campaign continues, legislation to create an ONN has not been reintroduced for the current, 110th Congress—ANA will continue to monitor the issue and keep you informed.

I hope that this information is helpful to you in addressing this issue in your state. If you have questions or would like to talk more about the issue or the letter, please contact me at michelle.artz@ana.org or 301-628-5087.

Michelle Arzt
Associate Director, Department of Government Affairs

October 2, 2007
To whom it may concern,

As organizations and individuals engaged in improving health on a daily basis, we are deeply committed to ensuring that our nation’s public health system is equipped to address both the basic health care needs of its citizens and the emergency preparedness needs of a post 9/11 world. We believe that we share these goals with advocates for the creation of an Office of the National Nurse, an initiative which began in May, 2005, and which included the introduction of federal legislation during the 109th Congress. However, while we respect the aims of the bills’ proponents and agree wholeheartedly that nurses must take the lead in addressing core challenges to nursing and health care, we hold deep concerns about the National Nurse proposal.

These concerns center on three general areas: the initiative’s proposed creation of new programs that are redundant with existing public health entities and systems (such as the U.S. Public Health Service Chief Nursing Officer, Public Health Nursing and the Medical Reserve Corps); the recognition that limited resources are available to fund existing programs, let alone establish new ones and; the need to ensure that the proposal’s public health education efforts go beyond simple messages to incorporate proven, evidence-based interventions.

Rather than creating new, parallel offices and volunteer structures, we believe we should invest in and reinforce our existing public health infrastructure and resources. While there is no magic-bullet solution to the challenges facing our public health system, actions such as strengthening the position of Chief Nurse Officer, bolstering the existing public health nursing network, and investing in evidence-based public health education could make a real and positive impact and move us toward our common goals.

Recognize and Strengthen the Chief Nurse Officer (CNO)

We have a national nurse in the position of Chief Nurse Officer (CNO) of the United States Public Health Service (USPHS). The CNO provides advice to and works with the U.S. Surgeon General on policy issues related to nursing and public health, and represents the Office of the Surgeon General and the USPHS in contact with groups at the state, national and international levels and with professional societies concerned with nursing and public health issues. The Commissioned Corps of the USPHS is one of the seven uniformed federal services, with 6,000 active-duty officers. The Nurse Category is the largest with just over 1,350 Bachelor’s prepared registered nurses. The Chief Nurse also represents an additional 2,600 civil service and tribal nurses.

Enhancing the role, the current shortage of public health nurses and public health nursing leadership and faculty is a critical issue that must be addressed. Without attention to these workforce issues, the supply of public health nurses will remain inadequate, our communities will be vulnerable in the event of an emergency, and our goals for the nation’s health will remain unmet.

Invest in Public Health Education

Health education alone has not been shown to create the behavioral changes needed to ensure change in lifestyle, and public health education efforts must go beyond simple health messages to be effective. Health education efforts must be interdisciplinary, and they must reflect the science of population-based interventions, such as partnerships with populations and communities most at risk, and use of social marketing concepts as a basis for affecting community-wide changes that support healthful behaviors. Finally health education is only a part of meaningful change for individuals and communities, not a solution in and of itself. These efforts will not be fully effective unless public health workforce issues are addressed.

We welcome the added attention to the nursing profession, the current nursing shortage, and nurses’ role in public health that the National Nurse initiative has fostered. We hope that the resulting dialogue will lead to a renewed, lasting investment in the existing nursing and public health network, and we look forward to working together to address our nation’s public health needs.

Sincerely,
Commissioned Officers Association (COA)
American Association of Colleges of Nursing (AACN)
American Nurses Association (ANA)
American Organization of Nurse Executives (AONE)
American Public Health Association (APHA)
Association of Community Health Nursing Educators (ACHNE)
Association of State and Territorial Directors of Nursing (ASTDN)
Public Health Nursing Section, American Public Health Association
Mary Pat Costig, MPH, RN, FAAN
Quad Council of Public Health Nursing Organizations
ANA supports the removal of barriers and discriminatory practices that interfere with full participation by advanced practice registered nurses in the health care delivery system.

Background

The Balanced Budget Act of 1997 (P.L. 105-33) expanded reimbursement opportunities for advanced practice registered nurses (APRNs) by removing geographical and practice site restrictions for Medicare Part B reimbursement. However, APRNs continue to face significant barriers presented by other changes in the health care delivery system. These barriers include restrictive reimbursement policies of both the Medicaid program and private insurers as well as numerous state laws and regulations. Among the latter are those that limit prescriptive authority, require supervision by or collaboration with another health care provider, limit direct reimbursement, prohibit or limit institutional privileges, and make it difficult to obtain liability insurance.

In addition, as managed care organizations have grown to dominate health care delivery, increasing numbers of managed care organizations have become multi-state corporations that establish their own set of rules. These rules include the exclusion from access to managed care organization provider panels and the imposition of additional practice restrictions. New strategies need to be developed and implemented to promote the recognition of APRNs as cost-effective valuable providers, to counteract these additional barriers and to counteract the increased efforts by organized medicine to limit APRN practice. ANA believes that the solution to the removal of these practice barriers must be addressed at both the federal and state levels as well as throughout health care systems, including federal systems, private insurers, fee-for-service structures, and managed care.

Chemical—Radiation Exposure Linked To Health Risks

Nurses who are exposed to high levels of chemicals and drugs on the job are more likely to report having asthma, miscarriages and some cancers, according to a survey released today.

More than 1,500 nurses nationwide, including a sample from Missouri and Illinois, were asked last year about their health histories and on-the-job exposures to cleaning products, radiation, mercury and other potentially hazardous materials. The survey was conducted by the Washington-based nonprofit Environmental Working Group.

Nurses who said they were exposed to high levels of radiation reported a 20 percent higher rate of breast cancer compared with nurses who had little or no exposure, according to the survey. High levels were defined as exposure at least once a week for 10 years or longer.

High exposures to any type of medication were associated with a 14 percent increase in cancer rates. Asthma rates were up to 50 percent higher in nurses who reported high exposures to disinfectants, cleaners and latex. Nurses who said they had high exposures to cancer drugs reported about 20 percent more miscarriages.

"As nurses, the patient is always first, and we don't think about ourselves," said Pamela Levin, a nurse and professor at Rush University Medical Center in Chicago. "It's really time to focus on how to create a healthier workplace for the nurses."

The questionnaire was co-sponsored by the nonprofit group Health Care Without Harm, the American Nurses Association and the University of Maryland's Environmental Health Education Center.

The results should be considered preliminary because they only suggest a link between the chemicals and the risk of disease, said Rebecca Sutton, a staff scientist for Environmental Working Group.

The 1,500 nurses who answered the questionnaire are a relatively small sample of the 4 million-plus nurses practicing in the U.S. The study did not take into account other factors such as smoking habits and age.

The goal of the nurses survey is to encourage hospitals to minimize risk to nurses and other health care workers while inspiring further research into hazards in the health care industry, researchers said.

"Our results were not exactly astounding because they're quite in line with a lot of other studies looking at a few of these hazards individually," said Sutton. "For me, what was most surprising is that nurses actually have very few health protections on which they can rely."

Local health care administrators said there is a growing awareness of risks from hazardous materials and disagreed with the notion that nurses are not well-protected.

"While it's not by any means perfect, the degree to which there are methods of protecting oneself when you know you're handling a hazardous chemical or drug has improved tremendously in the last few decades," said Judy Headley, a nurse research scientist at the Siteman Cancer Center at Barnes-Jewish Hospital.

At St. Louis Children's Hospital, that has meant limiting the use of latex gloves, improving ventilation and monitoring workers' exposures, said Debbie Mays, director of risk services. "Working with chemicals and medications that are hazardous is a part of health care," Mays said. "The key to using those products is proper monitoring, proper personal protective equipment and administrative control."

Rationale

The removal of arbitrary practice restrictions is crucial to achieving universal access and coverage of health care services. The full participation of registered nurses in the health care system will make access to health care affordable, available, and accountably.

ANA has consistently supported reimbursement and practice policies to ensure that all nurses are able to participate in health care systems without artificial barriers preventing their ability to practice and to be paid for those services. ANA supports legislation that prohibits discrimination by individual health plans based on the type, license, class, or specialty of a health care provider. Health plans must be required to make public, in advance, the criteria used to select participating providers and must have a sufficient mix of providers to ensure enrollees adequate access to covered services. States must not have the authority to impose on any class of healthcare professionals arbitrary practice restrictions that are not based on the licensure of those professionals. Specific language should direct states to eliminate practices that prevent registered nurses from delivering health care within their scope of education, abilities, and competence.

ANA supports initiatives that remove arbitrary practice restrictions or prohibit policies that promote barriers for APRN practice including any laws, regulations, or policies that limit or prohibit prescriptive authority, require supervision by another health care provider, limit direct reimbursement, prohibit or limit institutional privileges, and make it difficult to obtain liability insurance.

Nursing’s Legislative Continued Nursing’s Legislative and Regulatory Initiatives for the 109th Congress
American Nurses Association, Department of Government Affairs
Phone: (301) 628-5094 • http://www.anapoliticalpower.org
National Perspective on Status School Nursing

Amy Garcia, Executive Director for the National Association of School Nurses (NASN), provided a national perspective on the state of school nurses. She revealed a wide disparity in school nurse to student ratios between states, within states, and within districts, although it seems there is no significant difference between RN staffing of low income schools and non-low income schools. According to NASN’s study, 64.8% of schools in the US have at least one full time RN, while 1,151 is the average total students per RN, with only 13 states having less than 750 total students per RN. Key to addressing the inadequate supply of nurses in schools extends beyond funding— it’s about public perception of what a nurse does. School nurses report 58% of time is spent with direct care for acute conditions, health screening (40%), direct care for chronic conditions (58%), administrative reports and student health plans accounts for 32%.

ANA Launches New Safe Staffing Website

The American Nurses Association (ANA) has launched a new web site dedicated to the issue of safe staffing. The new site educates nurses about ANA’s history of advocacy on the issue, provides updates on the newest information and developments, and gives nurses tools to get involved.

The site allows nurses to share their own stories and concerns and invites them to help strengthen the case for safe staffing legislation by completing a survey. Through the site, nurses can also stay informed about the latest developments on Capitol Hill and contact their members of Congress to urge their support.

“ANA has been a persistent driving force in the efforts to make safe staffing legislation a reality,” said Linda I. Sizerle, MSN, RN, CNA-ABC, CEO of the American Nurses Association. “This site gives nurses a stronger voice, and empowers them to take an active role in impacting their workplace environment.”

“Safe staffing saves lives,” added Rebecca M. Patton, MSN, RN, CNOR, President, American Nurses Association. “There is a growing body of evidence that demonstrates adequate staffing improves the health outcomes of patients, resulting in fewer inpatient days, complications and deaths. Implementing safe staffing levels should be seen as a critical investment in quality, cost effective care, and ANA’s goal with this web site is to establish staffing levels that promote a safe and healthy working environment for nurses, and ensure the highest possible patient care.”


Mary McNamara, 510-628-5198 mary.mcnamara@ana.org www.nursingworld.org/rev/rnnews/

Center Unveils New Online Forum for Nurses: Ask Amanda RN

Every Wednesday at 11 am PST through Dec. 19, the Center for American Nurses invites all nurses to participate in its new interactive online forum, Ask Amanda RN, where nurses will get resources and discuss topics impacting their daily work and their careers.

Get the facts and share your views about lateral violence in the workplace and the use of agency nurses, or learn the latest about technology at the bedside, nurse fatigue or securing your financial future.

Visit www.centerforamericanrn.org and click on the Ask Amanda RN link for more information. Chats will remain after the holidays on Wednesday, Jan. 9.

ANA Staffing Bill Reintroduced in the House

On November 9, Reps Lois Capps (D-CA) and Ginny Brown-Waite (R-FL) introduced H.R. 4138, the Registered Nurse Safe Staffing Act. Like its companion bill in the Senate, S. 73, H.R. 4138 would hold hospitals accountable for the development of valid, reliable unit-by-unit nurse staffing plans. These plans would be developed in coordination with direct-care registered nurses (RNs) and based on each unit’s unique characteristics and needs.

Insufficient nurse staffing is among the top concerns for nurses today. Accordingly, securing appropriate staffing to protect nurses and patients remains a major priority for ANA. While there is widespread agreement in the nursing community about the current staffing crisis, debate over the best solution to this problem continues.

ANA supports the establishment of nurse-patient ratios to address the current crisis, but feels strongly that these ratios must be set, not by legislators, but in the workplace, in direct coordination with nurses themselves, and based on unit-by-unit circumstances and needs.

This approach, based on ANA’s Principles for Nurse Staffing, treats direct-care nurses as more than just a number in a ratio. The RN Safe Staffing Act recognizes nurses as professionals and it requires that they play an integral part of staffing plan development and decision-making by giving them a say in the care that they provide.

While ANA respects all attempts to address the staffing issue, we have real concerns about the establishment and legislation of fixed nurse-to-patient ratios in federal or state legislation. Such legislated numerical ratios seem to offer a concrete solution, and may appear to be a good fit for some workplaces. However, so many other variables—factors including safety of patients, level of experience of nursing staff, layout of the unit, level of ancillary support—are key to establishing the “right” nurse-patient ratio for any one unit.

This is why ANA initially worked with Sen. Daniel Inouye (D-HI) and Rep. Lois Capps (D-CA) during the 109th session of Congress to develop and introduce the Registered Nurse Safe Staffing Act. In the current, 110th Congress, Senator Inouye has again sponsored the Senate bill, and we are pleased to report that Rep. Ginny Brown-Waite (R-FL) joined Rep. Lois Capps (D-CA) this session as a lead sponsor of the House bill.

At introduction, the bill had 15 additional co-sponsors, including Republican Rep. Steven LaTourette of Ohio. Rather than setting a specific numeric ratio, the Registered Nurse Safe Staffing Act requires the establishment of a staffing system that “ensures a number of registered nurses on each shift and in each unit of the hospital to provide for appropriate staffing levels for patient care.”

Specifically the staffing system must:

• Be created with input from direct-care RNs or their designated representative;
• Be based on the number of patients and patient acuity level, with consideration given to patient admissions, discharges and transfers on each shift;
• Reflect the level of preparation and experience of those providing care;
• Reflect staffing levels recommended by specialty nursing organizations; and
• Provide that an RN not be forced to work in a particular unit without having first established that he or she is able to provide professional care on such a unit.

Another key provision of the Act is the requirement of public reporting of staffing information. Under the provisions of the Act, hospitals would be required to post daily the number of licensed and inpatient RN staff providing direct patient care on each unit and each shift, while specifically noting the number of RNs.

Finally, the bill provides whistle-blower protections for RNs and others who may file a complaint regarding staffing, establishes procedures for receiving and investigating complaints, and creates enforcement mechanisms, including civil monetary penalties, that can be imposed by the Secretary of Health and Human Services for each knowing violation.

ANA needs your help to educate members of congress and build co-sponsorship of this important legislation, and we will soon unveil a tool kit with new resources to help you get involved.

So please contact your members of Congress and urge them to support S. 73 / H.R. 4138.

Michelle Artz, ANA Government Affairs
The following are examples of email updates you could as a member receive weekly. (These were received the week of Dec 1; just prior to sending in copy for this newsletter)

**ANA Insider**
1. SIDS Risk Reduction CE Program
    Emphasizes Important Role of Nurses in Health Care
2. ANA Statement on RWJF’s Center to Champion Nursing in America
3. Chemical Exposures on the Job May be Linked to Diseases in Nurses
4. Honor a Nurse – Recognition from the Heart
5. ANA Launches New Safe Staffing Website
6. ANA’s Virtual Voting Booth—Coming Soon to a Computer Near You!

**ANA SmartBrief**
1. High-tech OR advances aim to reduce errors
2. Healthcare Certificates 100% Online
3. Experts: Selective use of chemo for breast cancer patients possible
4. Teen substance abusers may benefit from new therapy
5. Florida 5-2-1-0 plan designed to reduce childhood obesity

**Trends & Technologies**
1. Web site connects hospitalized children
2. FDA panel supports approval of Holocent sterilization device

**Work-Life Balance**
1. VA one of best health care systems in U.S.
2. Ohio Board of Regents approves nurse doctorate program
3. Chicago-area students make blankets for hospitalized children

**Legislative Policy & Regulatory News**
1. Stalemate calls into question government’s health care role

**ANA News**
1. A Crocs discount just for you!

**Capital Update**
1. ANA staffing bill reintroduced
2. House Fails to Override Veto of Health Funding; Future Remains Uncertain
3. ANA’s Presidential Endorsement Task Force Meets with Governor Bill Richardson
4. AMA Defines Intervventional Pain Management as Practice of Medicine;
5. Debates Health Reform, Medicare At Interim Meeting
6. ANA’s Virtual Voting Booth - Coming Soon to a Computer Near You!
7. SCHIP Negotiations Stall
8. AHIC Recommends Mandatory E-Prescribing in Medicare
9. CMS Lists Poorest-Quality Nursing Homes on Web Site

**Funding for Nursing Workforce Development Programs**
The American Nurses Association is pleased to announce that nurses have made their voices heard on Capitol Hill. A budget battle between Congress and the White House threatened vital funding for nursing workforce development programs. ANA urged nurses to call and write lawmakers to urge them to invest in nursing. A year end spending package includes a $6.4 million increase in FY 2008 funding for the Title VIII nursing workforce development programs.

ANA has been a driving force in efforts to increase funding for the Nursing Workforce Development programs administered by the Health Resources and Services Administration (HRSA) under Title VIII of the Public Service Act. HRSA administers the nation’s nursing education programs that are designed to recruit new nurses into the profession, promote career advancement within nursing, and recruit nurses into critical shortage areas.

For more information on this vote, and on how you can join ANA’s fight for nursing issues on Capitol Hill, please visit: http://rnaction.org/politicalpower/home.tcl

**ANA Offers Emergency Guidelines**
In the event of a large-scale emergency, the American Nurses Association (ANA) has drafted recommendations for nurses and other healthcare professionals to adopt when resources are scarce or care delivery occurs outside normal operating conditions.

The document, “Adapting Standards of Care under Altered Conditions,” suggests healthcare professionals receive continuing education on emergency preparedness, and provide clear information to employers about limitations on work availability or special skills that apply to emergency conditions.

The report also recommends that healthcare facilities expect emergency teams to include volunteers with varying skill levels and that they be able to educate staff quickly and reconfigure clinical teams and physical resources. The ANA expects to make the final document available in January.
Creating a dedicated "SWAT-like" team of intensive care specialists who respond quickly to calls for help throughout the hospital can help decrease heart attacks and deaths, and prevent patients from deteriorating so that they must go on mechanical breathing devices.

Data gathered from May 2005 to May 2006 on the impact of the critical care response teams on 342 patients in Toronto General Hospital, University Health Network (UHN). The team is a portable intensive care unit (ICU) which responds within minutes to a call for help. By responding quickly, they can prevent patients from getting so sick that their heart stops or they stop breathing. Despite what television or the movies show, if a patient's heart stops while in the hospital, the chances of survival are poor about 12%, says Dr. Stuart Reynolds, an ICU physician at UHN who is also the Ontario physician that leads in expanding the teams throughout the province. RRT's critical care response or "outreach" team is composed of an ICU physician, nurse, respiratory therapist, and the teams are available 24 hours a day. Every patient who is discharged from the ICU into the ward is automatically followed for 48 hours, and staff are educated about any symptoms which would indicate that the patient's condition is worsening.

"We provide that extra set of eyes and ears to help the teams on the wards," says Mugs Zweerman, an ICU nurse who has worked with RRT's critical care outreach team from the beginning. "We're a welcome resource for staff who feel more secure because they can say, 'Hi Mugs, can you just take a peek, I'm worried about this patient.'" Mugs also noted that the team is another resource for the families of patients, providing continuity of care, especially when a patient has previously been in the ICU for a long time.

Dr. Reynolds also noted that UHN is in the forefront of developing tools to help the critical care response teams raise awareness of hospital staff about what they are able to do, and how they can help bring the expertise and resources of a critical care unit beyond its walls to meet patients' needs anywhere in the hospital. "Imagine the impact such teams could have by bringing to patients the critical care skills, knowledge and equipment when and where it is needed."

Education is an important part of the RRT and consists of a seven-part program to improve critical care access, quality and seamless co-ordination of services, with establishing best practices in ICUs, e-learning, critical care training programs, end-of-life communications courses, information systems and other novel initiatives. Members of the RRT are expected to mentor you and each other so that you can identify and treat or anticipate similar problems in the future. If you would like to learn more about the rapid response team concept, you may want to check out the website: www.rapid-response-teams.com

Attend Online Webinars

These are seminars that are conducted on the internet. Many of them are free and can be played back after the live event. One that you might be particularly interested in is a webinar about complementary and alternative medicine done by the National Institute of Health. The website address for this is www.nccam.nih.gov/videoslectures.
Disasters do not happen every day, so communities now routinely hold disaster drills specific to the type of situation that could occur in their area to hone procedures and clinical skills and work through potential problems. Regardless of the type of disaster, EDs and critical care units are required to have a protocol in place and up to date so that staff can respond at a moment’s notice is essential. It’s important, for example, to understand the chain of command and know who has the authority to get things moving. Leadership is critical. Every staff member has a role and assigned responsibilities in the event of an external or internal disaster. What needs to be done and how to perform one’s specific role should be second nature. In this situation, practice does make perfect in terms of knowing one’s responsibilities—where to report and what to do. Disasters are unique experiences, and it’s not always possible to anticipate every contingency.

Previously most disasters lasted two to three days but Katrina showed that we need to be prepared for longer events. Nothing had prepared us for the magnitude of this hurricane and the prolonged period of isolation. Hospitals throughout the area were cut off from the outside world for days.

Is your hospital prepared to “do it alone,” things taken for granted like adequate food, water, electricity, phone service, and clean sheets, become issues; how do you access the medication system without electricity?

In the absence of established procedures, nurses must make decisions at a rapid pace that require quick and flexible thinking. They must have the expertise to serve as their health-care provider of choice. Who will be your doctor? As this valuable new resource grows and becomes the driving force in pressing for universal health care.

Who Will Be Your Doctor?

Mary O’Neil Mundinger DrP.H.

A quietly emerging trend in health care is likely to have a major effect on who will diagnose and treat your illness in the coming years. Rather than a physician, that comprehensive-care provider may very well be a nurse—who also happens to be a doctor.

As more physicians move toward specialities and away from general care, there is a troubling lack of providers in this critical health-care sector. The need is even more urgent in light of the growing number of Americans who are suffering from chronic illnesses such as asthma, diabetes and hypertension and require long-term disease treatment and coordination of care. Many others who survive extraordinary medical interventions or trauma need sustaining care for the rest of their lives.

The role of nursing has changed dramatically with new procedures and medications and those who have been out of the work force, even for as little as 4-5 years, find they have fallen behind in the practice of nursing.

The nursing schools currently are trying to fill that void with refresher courses; a crashed-down version of undergraduate nursing curricular program that vary in length, cost, and clinical time, with some requiring internships.

The refresher courses provide a strong base for those returning to the field and provide self-confidence that they can handle the requirements of their role. Many refresher course students state that the new complex procedures and therapies require hands-on experience, and that clinical experience with a preceptor is a key component in the teaching/critical thinking experience.

The courses available in Nevada are:

Truckee Meadows Community College: www.tmcc.edu or 775-445-6400

Community College of Southern Nevada: www.cssn.edu or 702-651-5684

In Pictures: Innovative Health-Care Solutions

One of the major changes to consider is emergency evacuation. Many hospitals have taken a more active role and have established their own emergency evacuation plans rather than relying solely on FEMA to decide when to evacuate and where to send patients. Hospitals have responded by being more aggressive in discharging patients before an anticipated disaster situation. With food, water, and supplies at a premium, most hospitals cannot afford to feed, clothe, and care for patients who are medically stable enough to be discharged. This goes for staff as well, only essential personnel will stay.

The unexpected aspect that arose was the human factor. The staff anticipated a couple of days on alert and left home without extra clothing, food, or their own medications. The staff’s needs became similar to the patients; they too required food, water, electricity, clean clothes, and medicines. When telephones failed, they no longer had contact with their families, which caused additional stress. Those who had neglected to set up their own emergency action plans with their families had no idea where their loved ones were or whether they had been evacuated safely. Most of those involved with Katrina now have an emergency backpack filled with necessities that they will take to work when a disaster looms.

An important factor that came to light as a result of the twin towers' collapse in New York—and that was reinforced during Hurricane Katrina—was the importance of having system-wide emergency response procedures, a common nomenclature, and a pre-established process for communicating information across disciplines. A registered nurse or other healthcare personnel must speak the same technical language, use the same terminology, and respond according to a pre-established policy. While many states are still in the planning mode others have implemented disaster response systems.

The Registered Nurse Response Network

RNWs vowed to change the way disaster relief occurs in this country. The experiences at Katrina gave birth to RNRRN—the Registered Nurse Response Network, the first national network of direct care nurses that coordinates the deployment of volunteer RNs to disaster stricken areas when a disaster occurs.

One year after its formation RNRRN has signed up over 4,000 RNs to relieve their beleaguered colleagues in the next disaster zone. The project has conducted classes in over 16 cities examining the RNs unique ability to be the driving force in pressing for universal health care and disaster preparedness/response standards. Class participants are registered nurses who, by joining the network, they are taking steps to ensure that the tragedies of Katrina are never repeated.

Nurses can’t prevent natural disasters, but we can help prevent man-made ones. That’s why we need to join together to be ready the next time disaster strikes, and are taking the necessary measures to ensure our health care systems are ready too.

Do you part and investigate if your city, facility is ready. Consider joining the system set up in Nevada or the national organization. Do it now, for we never know when a disaster will strike again.

WHO Calls Graveyard Shift a Probable Carcinogen

People who work the overnight shift are at a higher risk for developing certain cancers, perhaps because working the graveyard shift disrupts the body’s circadian rhythms and possibly inhibits the production of melatonin, a tumor-suppressing hormone. The WHO’s cancer organization will list the graveyard shift as a probable carcinogen in the next month, and the American Cancer Society is expected to follow suit.

Practice Issues

Getting Back into the Field

Refresher RN Nursing courses provide a ‘catch-up’ for returning nurses. ‘An RN is always an RN’ is often stated; but after a break from practice, is she qualified to be a nurse in today’s expansive technological world?

The role of nursing has changed dramatically with new procedures and medications and those who have been out of the work force, even for as little as 4-5 years, find they have fallen behind in the practice of nursing.

The ever-changing, ever-evolving role of nursing can be a challenge for a nurse who has to do more decision-making and deal with patients who are much sicker in faster-paced environments with fewer nurses. Drug therapies and surgical procedures have evolved and patients are discharged quicker, meaning today’s nurses must be able to explain complex home treatments.

The nursing schools currently are trying to fill that void with refresher courses; a crashed-down version of undergraduate nursing curricular program that vary in length, cost, and clinical time, with some requiring internships.

The refresher courses provide a strong base for those returning to the field and provide self-confidence that they can handle the requirements of their role. Many refresher course students state that the new complex procedures and therapies require hands-on experience, and that clinical experience with a preceptor is a key component in the teaching/critical thinking experience.

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The doctor of nursing practice (DNP) is a new level of medical practice. In addition to expert diagnosis and health management. It is the future we all need and want.

As more advanced-practice nurses pursue this new level of clinical training, we are working to create a board certification to establish a consistent standard of competence. To that end, we are working to enable DNPs to take standardized exams similar in content and format to the test that physicians must pass to earn their M.D. degrees. By allowing DNPs to take this test, the medical establishment will give patients definitive evidence that these skilled clinicians have the ability to provide comprehensive care indistinguishable from physicians.

Along with a doctorate and the title of ‘doctor,’ the fact that a midwifery or nurse practitioner has fulfilled this certification requirement will instill confidence in patients that DNPs have the expertise to serve as their health-care provider of choice.

Nurse practitioners are reimbursed by Medicare and Medicaid in every state, but only variably by commercial insurance carriers. That is certain to change soon, as these DNP graduates prove they are the logical choice to become the new comprehensive-care clinicians.

As this valuable new resource grows and becomes fully established, the health-care system’s ability to meet the nation’s desire for accessible, high-quality care will be greatly improved, yielding better health for all. Medical specialists are in short supply; patients increasingly need their care. With the advent of the DNP clinicians, we can have both dedicated, brilliant specialists and effective health management. It is the future we all need and want.

Mary O’Neil Mundinger, Dr.P.H., is the Dean of the Nevada RN formation • Page 17 • February, March April 2008
**Practice Issues**

**Hiring One Extra Nurse Might Help Hospitals Save Lives**

The American Nurse Credentialing Center (ANCC) has issued an alert warning that the organization “MedCEU” is neither accredited by ANCC nor approved for CEUs. This means that if you take a continuing education course through MedCEU, it will not count and be denied toward your renewal requirements. Information on how to determine whether courses by a continuing education provider are accepted for renewal can be found on the Board’s website.

If hospitals added one more full-time registered nurse on staff to care for patients, the number of hospital-related deaths in the United States could decrease significantly, according to a new review. However, cost concerns and a worsening nursing shortage might make this an unlikely scenario.

When asked how hospital administrators can be better made aware of these possible rates of improved patient outcomes, lead author Robert Kane, MD, said, “The issue is that they don’t have the resources to be convincing that it is in their best interests to act on it. From a business perspective, the savings in reduced lengths of stay would pay for the increased costs of the added staffing.” The case would have to be made in terms of image and liability.

The systematic review aimed to examine whether there was a link between a hospital’s registered nurse-to-patient ratio and the health outcome of the patients under their care.

The researchers evaluated 27 studies of patient outcomes in relation to the registered nurse-to-patient ratio. Per shift, RN staffing averaged about three patients per RN on surgical units and four patients per RN for medical patients. Registered nurse staffing ratios came from the American Hospital Association and other nursing surveys. The studies included in the review used data on patient outcome rates from sources such as the Uniform Health Discharge Data Sets and Centers for Medicare and Medicaid Services databases.

Kane and fellow reviewers found that a greater number of RNs on staff was associated with a reduction in the number of hospital-related deaths and other negative outcomes. Their results showed that by increasing the number of full-time RNs on staff per day by one, there were 9 percent fewer hospital-related deaths in intensive care units, 16 percent fewer deaths in patients and 6 percent fewer deaths in medical patients. For every 1,000 hospitalized patients, the reviewers estimated that an increase by one full-time RN per patient day could save five patient lives in intensive care units, five lives on medical floors and six surgical patient lives.

Moreover, increasing staffing by one RN per patient day resulted in lower rates of hospital-acquired pneumonia, respiratory failure and cardiac arrest in intensive care units. Patients’ length of stay in the hospital was also shorter by 34 percent in intensive care units and by 31 percent in surgical units.

The review acknowledges that while increased nurse-patient ratios can lead to better patient outcomes, it is difficult to maintain a reasonable number of RNs on staff in light of the current shortage of available RNs. “A sufficient supply of nurses is critical to providing our nation’s population with quality healthcare as these studies note; yet, hospitals are currently facing a nursing shortage,” agreed Jo Ann Webb, senior director of federal relations and policy for the American Organization of Nurse Executives. “This need will only be exacerbated in the coming years to accommodate growing patient needs and to replace retiring nurses.”


Linda Napier MSN RN ANA Associate Director, State Government

Linda Napier RN

Nursing is not for the faint of heart. Many a time when my partner asks, “How was your day?” and I start to speak, Jonathan puts his hands over his ears and yells, “la, la, la” to drown out my story. Why does he ask? You’ve got me. It’s not glamorous or sexy like on TV. It’s hard work with blood and body fluids, foul odors, often going into places where others fear to tread. Nurses work long hours (often nights). They use their names. They said they were afraid that what they were doing was not right or if they asked for permission to publish, it might bring shame on the names they used against them by their employer or coworkers. As one put it, “You just never know—there’s a lot of mistrust.”

One nurse told me that when she graduated from nursing school, all her nurses were Catholic and nursing was part of the caring culture of the church. Once health care was changed to a business model and institutions needed to comply to stay in business,” everything changed. Rather than being paid for services rendered, the fee was defined by the disease or procedure. If you had a gallbladder removed, the provider was paid for a certain predetermined amount of days and services. Basically, this business model dictates how much time patients have to be sick and even to die. Of course, patients are not machines and these things can’t be predetermined.

The business culture also thinks it can tell nurses how to be nurses—I’ve personally been told many times that I’m spending “too much time” with patients. So why are American nurses an endangered species? Because just by their very nature, because they care so deeply for others, it is often to the detriment of their own health. They’re tenacious when it comes to advocating for their patients, but don’t usually care for themselves. Nurses are like rare and beautiful birds that are becoming extinct because of our health-care system’s change from caring to business. Just like an endangered species, nurses need protection.

I believe that what we value as a society, is what flourishes. The nursing profession is languishing; there’s a shortage and the “solution” presently being used to fill jobs has been to “in-source” nurses from other countries just like we’re outsourcing so much of our industry.

It seems Americans want more and more for less—but at what price? The recent news of safety concerns about many imported goods parallels the concerns we all should have about the health-care system we’ve collectively created. Until there is another way that our health care, as a nation, is funded—until we can get back to the caring culture, the bottom line will not be our health, it will simply be the bottom line and nurses will be extinct.

Linda Napier is a registered nurse, member of an endangered species and author of the book “Tender Medicine.” You can contact her via e-mail at lnapier@mags.net

Editor’s note: I received an interesting reply from the author when requesting permission to reprint. Here are her comments:

Dear Betty,

You're more than welcome to use my article for your newsletter. I've been overwhelmed with responses from nurses all over the country and thought, perhaps you could use their responses (many have, again, not wanted me to use their names). So many impassioned and poignant emails... Thanks.

Linda Napier

Every person I have in my human services classes are nurses. The nursing schools here have a waiting list that discourages future nurses. They are turning people away.

Catherine McMickle

I'm a diploma nurse, class of ’67, Catholic school. I went on several times to get my BSN. I got discouraged because the more classes I took the more business-like it got! Not everyone wants to be a leader some of us wanted to stay "in the trenches" (so-to-speak). Some leaders in nursing education are afraid of the students to be trained, to have a foot in the foot. The last time I stopped taking nursing classes toward my degree was when I was taking a leadership class (required). I wrote my paper on a political project. I worked real hard & the group of nurses actually got SB180 passed but I did not write my paper up to their satisfaction. When asked how you do our jobs the way they're supposed to be done, there's a lot of mistrust. I’ve personally been told many times that I’m spending “too much time” with patients.

So why are American nurses an endangered species? Because just by their very nature, because they care so deeply for others, it is often to the detriment of their own health. They’re tenacious when it comes to advocating for their patients, but don’t usually care for themselves. Nurses are like rare and beautiful birds that are becoming extinct because of our health-care system’s change from caring to business. Just like an endangered species, nurses need protection.

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Handwashing More Useful Than Drugs In Virus Control

Tan Ee Lyn

Physical barriers, such as regular handwashing and wearing masks, gloves and gowns, may be more effective than drugs to prevent the spread of respiratory viruses such as influenza and SARS, a study has found.

The findings, published in the British Medical Journal, came as Britain announced it was doubling its stockpile of antiviral medicines in preparation for any future flu pandemic.

Trawling through 51 studies, the researchers found that simple, low-cost physical measures should be given higher priority in national health plans.

"Mounting evidence suggests that the use of vaccines and antiviral drugs will be insufficient to interrupt the spread of influenza," they wrote in the report.

The 51 studies compared any intervention to prevent animal-to-human or human-to-human transmission of respiratory viruses, such as isolation, quarantine, social distancing, barriers, personal protection and hygiene, to doing nothing or to other types of intervention. They excluded vaccines and antiviral drugs.

They found that handwashing and wearing masks, gloves and gowns were effective individually in preventing the spread of respiratory viruses, and were even more effective when combined.

"This systematic review of available research does provide some important insights ... There is therefore a clear mandate to carry out further large trials to evaluate the best combination of international team of scientists wrote.

Another study, published in the Cochrane Library journal last month, found handwashing with just soap and water to be a simple and effective way to curb the spread of respiratory viruses, from everyday cold viruses to deadly pandemic strains.

Researchers have long warned that the world is due for another pandemic but they cannot say which strain will strike. The H5N1 avian flu virus that has killed more than 200 people globally since 2003 is considered a prime suspect.

Researchers in New York believe they have solved one of the great mysteries of the flu: Why does the infection spread primarily in the winter months and how does the virus spread so quickly and been so deadly? The answer, they say, has to do with the virus itself. It is more stable and stays in the air longer when air is cold and dry, the exact conditions for much of the flu season.

"Influenza virus is more likely to be transmitted during winter on the way to the subway than in a warm room," said Peter Palese, a flu researcher who is professor and chairman of the microbiology department at Mount Sinai School of Medicine in New York and the lead author of the flu study.

As long as flu has been recognized, people have asked, Why winter? The very name, "influenza," is an Italian word that some historians believe originated in the mid-18th century as influenza di freddo, or "influence of the cold." Flu season in northern latitudes is from November to March, the coldest months. In southern latitudes, it is from May until September. In the tropics, there is not much flu at all and no real flu season.

Some of hypotheses are that flu came in winter because people are indoors. In school, crowded, and wearing masks, the flu virus cannot cross long distances and get into different people’s mouths. But Dr. Palese does not suggest staying in a greenhouse all winter to avoid the flu. The best strategy, he says, is a flu shot. It is unclear why infected animals released viruses for a longer time at higher temperatures. There was no difference in their immune response, but one possibility is that their upper airways are cooler, making the virus residing there more stable.

Flu researchers said they were delighted to get some solid data at last on flu seasonality. "It was great work, and work that needed to be done," said Dr. Terrence Tumpe, a medical microbiologist at the Centers for Disease Control and Prevention.

Study Shows Why the Flu Likes Winter

Influenza Virus Transmission Is Dependent on Relative Humidity and Temperature

Published: Oct. 19 issue of PLoS Pathogens: Amice C. Lowen, Samira Mahabkra, and John Steel, Peter Palese

Influenza virus is more likely to be transmitted during winter on the way to the subway than in a warm room, the researchers wrote. The H5N1 avian flu virus that has killed more than 200 people globally since 2003 is considered a prime mandate to carry out some important insights, they wrote in the report. There is no doubt that some historians proposed, originated in the mid-18th century as influenza di freddo, or "influence of the cold." Flu season in northern latitudes is from November to March, the coldest months. In southern latitudes, it is from May until September. In the tropics, there is not much flu at all and no real flu season.

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Use a Palm®

These devices can hold several textbooks’ worth of facts and fit into a shirt pocket. A calculator is built right in. I found that a Palm Pilot is just invaluable for clinical practice. When I walk into a patient’s room I have not only many different textbooks full of nursing information available to me at the patient’s bedside, but also a drug guide. So I do not have to be running around the floor looking for that drug guide. I do not have to be sitting on the phone with pharmacy waiting valuable time. I have the information available to me in my pocket.

This is a great way to hold facts. You do not need to be cluttering up your mind trying to memorize whole bunches of facts. You can free your mind to think so that you can put together those facts into good, organized and concise evaluations of facts. You can free your mind to think so that you can put together those facts into good, organized and concise evaluations of facts. You can free your mind to think so that you can put together those facts into good, organized and concise evaluations of facts.

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Skin Care: An Essential Component of Hand Hygiene and Infection Control

Linda Bissett

This article discusses a topic that is relevant in nursing today, the impact of skin care on hand hygiene and infection control. Proper hand washing is absolutely essential to infection control. McCormick and Wickett's research actually concluded that the use of oil-containing lotion or barrier cream protected bacteria on the hands of healthcare workers against irritation and skin breakdown and ultimately promoted more frequent hand washing. In the Introduction, the author could have included statistics showing how poor hand washing habits increase rates of infection. A discussion of the impact on healthcare from the spread of blood borne diseases associated with poor hand hygiene would have supported its relevance. This is especially important given recent discussions in the literature on increasing occurrences of Methicillin-resistant Staphylococcus aureus (MRSA) infections.

The author referenced studies showing that the prevalence of skin irritation among healthcare workers not using moisturizing creams actually caused a decrease in the frequency of hand washing. Additional statistics on how variables such as age, ethnicity, weather and climate were associated with healthier skin provided meaningful information.

The article revealed that skin irritation was primarily caused by hand washing, wearing occlusive gloves for long periods of time and contact with antimicrobial cleansers. Suggestions on how to limit the time spent wearing gloves and the types of gloves most likely to reduce skin irritation were included. The hand and nails before or after applying alcohol-based products to the hands led to dermatitis could be new important to many healthcare workers. The reason why this practice was recommended without the evidence to support was not clear. The article might have also mentioned research comparing differences in the skin quality from towel drying versus drying by towel lotion or barrier cream protected the hands of healthcare workers against irritation and skin breakdown, or bruising, or may present as an intact or open/ruptured serous-filled blister. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or demoderum.

Stage III: Full-thickness tissue loss. Sequestrates or fat might be visible but bone, tendon or muscle are not exposed. Undermining and tunneling might be present. Depth varies by anatomical location. The bridge of the nose, ear, occiput and forehead have subcutaneous tissue. Stage III pressure ulcers can be shallow, but areas of significant adiposity can develop in extremely deep Stage II pressure ulcers. Bone/ tendon are not able to absorb the water from the hands effectively or might be visible but bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The depth may vary by anatomical location. Stage IV pressure ulcers can extend into muscle and/or supporting structures—fascia, tendon, or joint capsule—making osteomyelitis possible. Bone/tendon is visible or directly palpable.

Stage IV: Full-thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. The depth may vary by anatomical location. Stage IV pressure ulcers can extend into muscle and/or supporting structures—fascia, tendon, or joint capsule—making osteomyelitis possible. Bone/tendon is visible or directly palpable.

Step 4: Program Evaluation
Vaccine administration rates should be provided to administrators and managers regularly throughout the season. Declination tracking of HCP who refuse vaccination should also be performed and reasons of declining addressed.

Best Practices
Below are recommended best practice strategies to improve HCP vaccination rates.

Support by Nursing Leadership
- Involve nursing leaders.
- Serve as role models.
- Motivate staff to receive vaccination.
- Communication and Education
- Develop a campaign slogan and logo.
- Provide communication and education via a wide array of tactics.
- Mandatory computer-based learning modules.
- Planning and Tracking
- Develop a multidisciplinary group on the planning team.
- Track in an ongoing database providing results to department managers and key leadership.
- Consider using mandatory declination forms to identify reasons to refuse vaccine.
- Administrative
- Offer vaccination at a variety of times including all shifts and weekends, during work hours.
- Extend convenience by using mobile carts.
- Designate nurses on each unit to provide vaccination co-workers.
- Provide vaccinations free of cost to all employees.
- Provide incentive prizes or competition between departments.

References
American Nurses Association. Everyone Deserves a Shot at Fighting Flu, 2005
American Nurses Association. Pandemic and Seasonal Influenza, 2009
Is it possible that my staph or MRSA skin infection will come back after it is cured?

If yes, it is possible to have a staph or MRSA skin infection come back (recrudesce) after it is cured. To prevent this from happening, talk to your healthcare provider's directions while you have the infection, and follow the prevention steps after the infection is gone.

If I have a staph, or MRSA skin infection, what can I do to prevent others from getting infected?

You can prevent spreading staph or MRSA skin infections to others by following these steps:

1. Cover your wound. Keep wounds that are draining or have pus covered with clean, dry bandages. Follow your healthcare provider's instructions on proper care of the infected wound. Pus from infected wounds can contain staph and MRSA, so keeping the infection covered will help prevent the spread to others. Bandages or tape can be discarded with the regular trash.

2. Clean your hands. You, your family, and others in close contact should wash their hands frequently with soap and water or use an alcohol-based hand sanitizer, especially after changing the bandage or touching the infected wound.

3. Do not share personal items. Avoid sharing personal items such as towels, washcloths, razors, clothing, or uniforms that may have had contact with the infected wound or bandage. Wash sheets, towels, and clothes that become soiled with warm, soapy water and a laundry detergent. Drying clothes in a hot dryer, rather than air-drying, also helps kill bacteria in clothes.

4. Talk to your doctor. Tell any healthcare providers who treat you that you have or had a staph or MRSA skin infection.

What should I do if someone I know has a staph or MRSA infection?

If you know someone that has a staph or MRSA infection you should follow the prevention steps.

Rub-a-dub-dub, How Clean is Your Hub? (Intravenous, Central, and Peripheral Port Care)

Heather Berry SN OSN, Amanda Broowell SN OSN, Molly Brown SN OSN, Lesli Drew SN OSN, University of Nevada, Reno, Orvis School of Nursing

Safe and proper port care is a major concern for Registered Nurses, yet it is often neglected in practice. It has been estimated that “250,000 cases of bloodstream infections are linked to vascular catheters; 12 to 25 percent of patients with these infections will die” (Hadayow, 2002, pg. 46).

Research has shown in the most common source of bloodstream infections is hub manipulation in both long and short-term catheters, underscoring the importance of meticulous port care. As nursing students, throughout our clinical rotations and in various areas of medicine, we have witnessed firsthand the inconsistencies in protocols regarding port care. As part of a senior capstone project and for the purpose of searching out our own answers, we have prepared the following information to educate nursing and medical staff on proper port care.

Due to the lack of protocol standardization and limited clinical studies, our research revealed only expectations and recommendations regarding port care as opposed to true evidence-based practice results. The expert recommendations are as follows:

- Wash hand thoroughly and dry gloves
- Change port and tubing after administering antibiotics, blood products, and lipid emulsions
- Have all medications that do not contain NaCl flushes, multiple alcohol swabs, Chlorhexidine swabs, medications.
- VIGOROUSLY SCRUB the port hub for 10-15 seconds between each connection

Follow Saline, Administration, Saline, Heparin Protocol (SASH):
- ETOH scrub
- Saline flush
- ETOH scrub
- Antibiotic/medication administration
- ETOH scrub

- Saline flush
- ETOH scrub
- Heparin administration (if central line is being used)

This illustrates the hub must be scrubbed 3-4 times prior to administering any medication, blood product, or antibiotic.

- DO NOT reuse with ETOH swab just prior to administration
- DO NOT Use the same ETOH swab more than once
- DO NOT Set hub down on any surface after cleaning

Stained bloodstream infections are preventable, so when in doubt, change the tubing and port. Tubing costs are a significant role in the transmission of MRSA. MRSA is a type of staph that is resistant to antibiotics called beta-lactams. Beta-lactam antibiotics include methicillin and other antibacterials.

References


How can I prevent staph or MRSA skin infections?

Practice good hygiene:

1. Keep your hands clean by washing thoroughly with soap and water or using an alcohol-based hand sanitizer.
2. Keep cuts and scrapes clean and covered with a bandage until healed.
3. Avoid contact with other people’s wounds or bandages.
4. Avoid sharing personal items such as towels or razors.

Are people who are positive for the human immune deficiency virus (HIV) at increased risk for MRSA? Should they be taking special precautions?

People with weakened immune systems, which include some patients with HIV infection, may be at risk for more severe illness if infected with MRSA. People with HIV should follow the same prevention measures as those without HIV to prevent staph infections, including practice good hygiene, covering any abcesses or abrasions with clean bandages, and avoiding sharing personal items such as towels and razors, and contact their doctor if they think they have an infection.

Can I get a staph or MRSA infection at my health club?

In the outbreaks of MRSA, the environment has not played a significant role in the transmission of MRSA. MRSA is transmitted most frequently by direct skin-to-skin contact. You can protect yourself from infections by practicing good hygiene (e.g., keeping your hands clean when washing with soap and water or using an alcohol-based hand rub and showering after working out); covering any open skin area such as abrasions or cuts with a clean dry bandage; avoiding sharing personal items such as towels or razors; using a barrier (e.g., clothing or a towel) between your skin and shared equipment; and wiping surfaces of equipment before and after use.

What should I do if I think I have a staph or MRSA infection?

See your healthcare provider.

Are staph or MRSA infections treatable?

Yes. Most staph and MRSA infections are treatable with antibiotics. If you are given an antibiotic, take all of the doses even if the infection is getting better, unless your doctor tells you to stop taking it. Do not share antibiotics with other people or save unfinished antibiotics to use at another time. However, many staph skin infections may be treated by draining the abscess or boil and may not require antibiotics. Drainage of skin boils or abscesses should only be done by a healthcare provider.

If visiting your healthcare provider the infection is not getting better after a few days, contact them again. If other people you know or live with get the same infection tell them to go to their healthcare provider.

February, March April 2008 Nevada RNformation • Page 21 •
Hepatitis C Virus Update

Hepatitis C virus is the most common chronic blood borne infection in the United States with an estimated 4.1 million American infected. World-wide there is an estimated 170 million persons chronically infected. The number of new infections per year has declined from 240,000 in the 1980s to 26,000 in 2004. Potential risk factors include contact with infected blood, instruments or needles - such as IV drug users, health care workers, or public safety workers. Additional potential risk factors include intranasal cocaine use, tattooing and body piercing. Before 1992 the hepatitis C virus was also transmitted through blood transfusions. All blood is now tested for the presence of the virus. The risk post-transfusion has been estimated to be reduced to 0.001% per unit transfused.

Because infection with the virus can be asymptomatic or have vague symptoms, as many as 60% of individuals infected are unaware that they carry the virus. Many are found as a result of routine blood tests. Chronic hepatitis C is a slowly progressive disease that may gradually advance over 10–40 years. When it is acquired in later life there is some evidence that it may progress faster. In those with cirrhosis due to hepatitis C there is an associated increase in the chance of developing hepatocellular carcinoma. Drinking alcohol can make the liver disease worse.

There is no vaccine to prevent hepatitis C. The best prevention is not to use IV drugs, not to share needles, razors, or toothbrushes. Think about the risks if you are thinking about getting a tattoo or body piercing; and get vaccinated against hepatitis B.

According to the Centers for Disease Control and Prevention (CDC), there is an association between sexual exposure to someone with a history of hepatitis, or exposure to multiple sex partners and contraction of hepatitis C. Women with hepatitis C do not need to avoid pregnancy or breast-feeding according to the CDC. Expectant and new mothers need to avoid pregnancy or breast-feeding according to the CDC. Expectant and new mothers should consider abstaining from breast-feeding if their nipples are cracked or bleeding.

Currently there are FDA-approved treatments for hepatitis C. Hepatitis C positive patients should be evaluated by their physicians for liver disease.

References:
1. The American Liver Foundation Fact Sheet on Hepatitis C http://www.liverfoundation.org/
2. Center for Disease Control Fact sheet on Hepatitis C http://www.cdc.gov

Find out more about gastrointestinal disorders with The GI System in Detail: http://www.ed4nurses.com/gi-in-detail.htm

Patti Radovich, MSN, RN, FCCM Clinical Nurse Specialist Consultant to Ed4Nurses, Inc. Reprinted by permission

TeleHealth: Home Monitoring Growing Fast

Worldwide use of remote patient monitoring in the home using telemedicine technologies has surpassed use of the technology in clinical settings, according to a new report from Datamonitor, a London-based research firm. The firm predicts the home-based market will grow at a five-year compound annual rate of 56%, compared with 99% in the clinical market.

An aging population combined with a shortage of clinicians is helping fuel the growth. Further, the report notes, preventive care through home-based monitoring can help combat rising health care costs and prevent hospital admissions.

Lack of insurance reimbursement, however, remains a major barrier to further growth. Other obstacles include making telehealth an integral part of the daily practice of medicine and integrating it into clinical workflow and electronic health records systems, according to the report.

The report, "TeleHealth's Increasing Role in Healthcare," covers the market, strategy and technology forces driving adoption of the technology. www.datamonitor.com

Lavender Book

Paula Schneider MPH, RN, CHPN

In working with patients who are going through their unique process of letting go of this life for the next, caregivers will often ask hospice workers, “What can I do besides just give medicines?” They report they feel useless and helpless just watching their loved one lying in the bed, apparently sleeping, often oblivious to this world.

One of the old stand-bys of hospice work is a small booklet entitled, “Gone From My Sight.” This small book was written by a hospice nurse from Kansas and it has been tremendously successful, as every hospice I have known of or worked for has bought it in large quantities and given it out to patients who sign up for hospice services. In a kind and gentle way, this little booklet helps the caregivers and family begin to recognize what their loved one is going through and gives signposts along the way in the form of symptoms and what to look for. Families say this little booklet is extremely helpful. In hospice circles, it is known as The Blue Book, because its cover is always blue.

Some wise person (I wish it had been me) came up with an idea for a booklet that has a lavender cover, and it is called, “Lavender Book. Spiritual Tools for the Dying.” This booklet was developed to provide families with spiritual tools that can be used before, during, and after their loved one’s death. It is intended to serve as a guide that can be individualized for each situation.

I love Lavender Book! I decided over a year ago to buy this booklet in bulk and distribute it to my patients’ families. And over the months, I’ve received feedback that they like it as much as I do. Some topics in the booklet are using music, creating sacred space, meditation, relaxation, including the children, guided imagery, massage, anointing, spiritual readings and prayer, and creating rituals. Some of these techniques are specifically for caregivers and some are for patients themselves. All have the potential to provide peace and comfort at a time of high stress and anxiety and none require the administration of medications or potent drugs.

Months ago, I got a new patient who had already entered into that stage of dying where she was non-responsive, waiting at the threshold to enter her next life. Her husband was benefit of grief-stricken and as I was about to leave him after ensuring he knew how to give the end-of-life comfort medications appropriately, he told me he felt so helpless and wanted to do more. I asked him what his wife’s favorite music was, and he told me. I invited him to put some of that music on and sit by her bed and read scripture, which he had already told me she enjoyed. The entire atmosphere in the room changed, as he became empowered to do some things to bring his wife even more peace and comfort! I left feeling like I had facilitated an ambience that would make the entire experience more meaningful and rich for both him and his wife. The Lavender Book gave me what I needed to make that happen.

Paula is a veteran registered nurse of over 31 years and has served in hospice work for seven years. Her mission is to "lead myself and others to personal and spiritual health," and working in hospice has helped her fulfill her life’s work. She currently works for a hospice in Northern Nevada as a case manager.

Editors’ note;

I requested from the author information on the two booklets mentioned in her article:

The blue book is correctly titled: Gone From My Sight: The Dying Experience by Barbara Kerns, RN
The price of a single booklet is $2 plus $1 for S & H. As more are ordered, the price goes down.
Barbara Kerns Books
P. O. Box 822139, Vancouver, WA 98682
www.blbooks.com

Lavender Book: Spiritual Tools for the Dying by a committee of authors
A single booklet is $4 plus shipping and handling (call for price). As with Gone From My Sight, as more are ordered, the price per booklet goes down.
Contact: Asante Hospice Services
2825 East Barnett Rd., Medford, OR 97504
Phone: 541-789-5002, Fax: 541-789-5239
Diabetic Foot Infection
Classification System Validated

The Infectious Diseases Society of America (IDSA) has designed a clinical decision support tool for foot infections in patients with diabetes to provide better outcomes for these patients. Foot wounds are among the most common and severe complications of diabetes and are now the most frequent cause for diabetes-associated hospitalization. Nearly half of these wounds become clinically infected. Classifying severity of infection may help clinicians determine what treatments are needed and how urgently they must be provided.

In 2004, a longitudinal study of 1666 people with diabetes by the IDSA and the International Working Group on the Diabetic Foot (IWGDF) indicated the predictability of the classifications system that increasing severity of infection was also associated with more-frequent lower extremity co-morbidities, such as peripheral neuropathy and arterial vascular disease, and with deeper infection-related bone and joint disease. The authors suggest that determining the severity of a foot infection in a patient with diabetes may help the clinician decide on hospitalization, whether to use parenteral or oral antibiotics, and how urgently surgery or other treatments need to be performed. "We believe that the simplicity of determining the components of this system, coupled with the strong suggestion of its clinical utility, may make it a useful instrument in helping clinicians determine which of their patients are at the highest risk for adverse outcomes from a diabetic foot infection," the authors conclude. "Perhaps more aggressive medical, surgical, and adjunctive measures could be directed at these patients, with the hope that this would improve their foot salvaging outcome. This system should also be useful for clinical research studies, to allow for comparisons among patients enrolled in various investigations." Clin Infect Dis. 2007;44:562-565.

Male Nurse Research Study

Gerri Moore a doctoral student at Dowling College is conducting a survey on male registered nurses and their perception of job satisfaction. His survey is now posted online and he would appreciate male nurse participation. The ultimate goal of his study is to aid in the recruitment and retention of male nurses in the workforce. To view the survey:

Please go to www.malernursemagazine.com and hit the “Ongoing Survey” on the left, then click on Ms. Geraldine A. Moore Nursing Survey to link you to the survey. Pass on this request to male nurses. Any questions call Gerri Moore, RN, BC, MS at: 516-547-5299.

Diabetic Foot Infection

It’s Elementary: Expanding the Use of School-Based Clinics

Julia Graham Lear, School of Public Health and Health Services George Washington University

School-based health centers have existed in California since the late 1980s, when the first centers were established in Los Angeles, San Francisco, and San Jose. At present, 146 centers provide primary care and mental health services to children in elementary, middle, and high school settings, primarily focusing on low-income children.

Governor Schwarzenegger now intends to increase the number of school-based health centers in California to 500 elementary school sites. This expansion has the potential to increase access to care for children, improve clinical outcomes, and save money for public and private payers of child health services.

This report draws on the past experience of California and other states in instituting these centers. The recent report looks at the role of health centers in providing care, describes their characteristics, including where they are located, what services they provide, the ethnicity of those served, and how the services are paid for. It also provides key lessons for expansion, including the importance of establishing a clearly defined model and the benefits of having a strong school health center association.

Empowering Better Nursing Care

David W. Woodruff, MSN, RN, CNS

Things can change around here. There is an initiative in healthcare called Transforming Care at the bedside. This initiative focuses on safety and reliability, care team vitality, patient centeredness and increased value to your patients and their families. This initiative involves a total transformation and significant cultural changes within your organizations to provide care that is patient centered.

We have all heard the horror stories of a patient who has had something drastically go wrong with their hospital care. But how many times do you hear great stories of fantastic care and other states in instituting these centers. The recent report looks at the role of health centers in providing care, describes their characteristics, including where they are located, what services they provide, the ethnicity of those served, and how the services are paid for. It also provides key lessons for expansion, including the importance of establishing a clearly defined model and the benefits of having a strong school health center association.

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We have all heard the horror stories of a patient who has had something drastically go wrong with their hospital care. But how many times do you hear great stories of fantastic care and other states in instituting these centers. The recent report looks at the role of health centers in providing care, describes their characteristics, including where they are located, what services they provide, the ethnicity of those served, and how the services are paid for. It also provides key lessons for expansion, including the importance of establishing a clearly defined model and the benefits of having a strong school health center association.

Empowering Better Nursing Care

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How Can Nurse Practitioners Help Your Facility? Experts Count

Nursing facilities are realizing that nurse practitioners bring to the table a number of skills and services that translate into improved outcomes in every arena.

Many nursing homes think it's worth the money to hire nurse practitioners per building, the quality outcomes offer the best marketing strategy. For one, nurse practitioners can provide assessment and clinical response more timely. NPs are in the facility so they can see the unstable patient and start treatment quickly without necessarily having to interrupt the physician immediately.

The NP can also help triage residents and know when the staff can handle a clinical issue or needs to talk to the doctor. The nurses may call the physician and say the resident has a fever. "But the NP can say it's a fever and I hear rales and the patient has had this before and we tried these medications which didn't work."

The bottom line: When you give the physician more complete assessment information about a resident's problem, you're going to get a better answer. NPs can also help interpret lab results. It's much easier to manage INRs and Coumadin dosing when you're in the building regularly and know first hand how the patient is doing—for example, if he has any subtle signs of bleeding.

11 Things That Hurt Women's Career Success
by Susanne E. Gaddis Phd

Nursing has always been a field dominated by women. According to the U.S. Department of Health and Human services, 94 percent of the nation's nurses are women. In order to succeed at work, it is important to be conscious of behaviors. Here are eleven common behaviors women often engage in that prevent their success. While this list is geared towards women, it will also serve as a useful tool for the male nurse.

- We don't ask... therefore we don't get

While men in the workplace often step up to the plate and ask for what they want, female colleagues frequently sit on the bench only to watch and fall behind in the game. Women often promote themselves, raise and better benefits slip through their hands because they never ask for them. You'll never score a homerun if you don't step up to the plate and ask for the pitch. Men are more likely to be assertive and direct with high-ups. Therefore, they are more likely to get what they want than women. When women do decide to ask, they often ask the wrong people. Many women will seek assistance from friends and colleagues before asking. If your name is on the roster, don't hesitate to play the game.

- We procrastinate

When women step up to the plate, often times it's too late. Not only does procrastination create unnecessary stress, it also puts you behind in the game. Many women and men experience what is termed "approach-avoidance" behavior. This is when you know what has to be done but you avoid it. Or: you get stuck in analysis paralysis, where you calculate every outcome before moving forward. Procrastination may seem like an innocent habit, however knowledge without action can lead to depression. Don't be a bench warmer in the workplace. Step up to bat now. The longer you avoid what needs to be done, the more it affects self-esteem, self-confidence and ultimately your success.

- We say “I’m sorry”

Unlike men, women have a tendency to overuse the phrase "I’m sorry" in the workplace. Not only do women say “I’m sorry” to apologize for what they’ve done, they’ll also apologize for other people’s actions as well. Don’t bash yourself in other people’s dirty water. Also know that when you apologize your word choice is critical. Rather than saying “I’m sorry” consider action words such as “I regret.” “I apologize for” or “forgive me” which are more direct and meaningful. Save the “I’m sorry” for when you’re shopping for a Hallmark card, not when you’re in the workplace.

- We say “I’ll try”

The difference between saying “I’ll try” and “I will” can be the difference between failure and success. By saying “I’ll try,” you set the stage for procrastination. By saying “I will” you create a mental commitment to yourself, which ensures you will achieve your goal. In addition, by telling others that you will try, you communicate a sense of doubt. “I will” communicates a sense of certainty.

- We’re not selective with whom we spend our time

Face it—sometimes you end up in the company of people who are more negative than positive. Ultimately, this reflects upon you. Our relationships are our base network. They need to be strong and encouraging. Most people have a tendency to stay in a relationship when the perceived benefits outweigh the perceived costs. Think about what happens when you get back less than you give. Don’t waste energy on relationships that are counterproductive. Find people who encourage you, challenge you and motivate you. Remember that sour grapes make for bad wine and a spoiled party.

- We use non-verbal’s that don’t work

Non-verbal communication conveys up to 90 percent of a message. By using strong and powerful non-verbal’s you can enhance your image and create the positively you want you. On average, women take up less space than men so it is important to claim your space. Rather than putting your hands in your lap, put them up on the desk, to be clear and concise with a wall at a meeting, sit at the table. If you have a desk at work, position it so you face the door and can easily greet those who walk in. Avoid using counterfeit non-verbal’s, like eye rolling and fake smiles. People can misinterpret them or become distracted. It is also important to be direct with your non-verbal’s. By making eye contact, nodding your head and keeping an open posture you’ll make a positive impression.

- We criticize ourselves

Do you speak negatively about yourself? If so, it can hurt your self-esteem and impact the way people view you. Approximately 70 to 90 percent of the words our brain processes are negative in nature. According to the Zeigarnik effect, people remember more negative events than positive ones. Therefore, when you talk negatively about yourself it sticks like a wad of gum on a shoe. If you can’t say something nice about yourself, don’t say anything at all.

- We over-communicate

Are you a talkaholic? Women use about 3,000 to 4,000 more words per day than our male counterparts. While communication is critical for success, too much talky-talk can be counterproductive. When you ramble, people become distracted and confused. You can also loose the idea you were trying to communicate. It is more important to speak directly with higher-ups. Therefore, they are more likely to get the message. Use more words than necessary?

- We over-commit

Many working women feel pressured to succeed at everything. However, remember that if you bite off a large chunk, you’re going to be chewing on it for a long time. You will put yourself in a bad position if you are successful at a few tasks rather than mediocre at many. Say no just as much as you say yes. When asked to take on a new task, take a step back and breathe! Evaluate your personal and professional schedule to find a comfortable balance.

- We don’t provide 3-step positive feedback

What are you doing to create a “good old girl network?” It is important to remember how hard the journey was that brought you to where you are today. Don’t get distracted with your own success and forget to say “thank you” to those who have guided you along the way. Realize that you have the ability to mentor others, so ask yourself, “Who can I help?” and then do it.

- We don’t tout our own horn

Positive impressions create positive results. Unnecessarily, many working women quietly watch from backstage as their male colleagues take center stage. Go for the lead role. As a professional it’s important to step out from behind the curtain and become more positively visible. Don’t fixate on negative traits and previous failures. Let people know about your accomplishments, talents and strengths. Actively create the positive image you want to create. Voice your personal and professional talent in the workplace and you’ll receive it in return.

Being conscious of your behaviors is the first step towards a positive change. Remember, improvement comes with time. When addressing these issues be patient with yourself.

Visit Dr. Susanne Gaddis’s Website at: www.TheCommunicationsDoctor.com

Statistic in the introduction was found at: http:// bhp.hrsa.gov/healthworkforce/forces/rrnoulation/ preliminaryfindings.htm
News You Can Use

Is This A “Four Letter Word”?  

Betty Razor  
Interim RNFormation Editor

Nurses are appropriately proud of their education, expertise and knowledge; but so many refuse to use a “Four Letter Word” even when they can make a difference.

Why don’t you use the most powerful word available. VOTE Did you vote in your NNA District election, Did you vote in your local election, what about nationally? Have you become the nurse that allows others to dictate who will lead by being silent?

All should be educated on political issues effecting their practice as a nurse. Take that big step especially with the very important local, state and national elections occurring in just a few short months.

First and foremost you need to register to vote. Do you know where to register, where and when to vote? This information is readily available online; even the procedure for absentee ballot is easily accessed via the secretary of state web page: www.sos.state.nv.us. The process is quick and easy.

Then become knowledgeable on the candidates. Again read, listen and check out information on the issues that are dear to your heart. One of the most unbiased sites is the League of Women Voters. They have a new site for the upcoming elections; check it out: www.vote411.org

NNA has been fortunate to have dedicated nurses that volunteer to be on the NNA state legislative committee that oversees the state committee activities effecting our lives, our children, our patients and our profession (see notes on the Interim Health Care Committee p. 8).

ANA Political Action Committee has provided on-going information to members and the public on important state and national issues via the Journal, web page and email items like the ANA briefs, Capital update and legislative alerts. This is one of the most effective tools to get the word out when your voice is required to contact legislators.

State legislator may discuss and propose legislative bills that will impact our day-to-day work activities. Some of the critical issues that we believe will surface are: safe patient handling, safe staffing, mandatory overtime, medical techs, nursing education (admissions and faculty concerns), use of the title of “Nurse” by non-licensed, scope of practice for APNs, violence in the workforce and others too many to mention.

Nurses need to use their vote—to be loud and strong on these issues. In Nevada we have an unusual legislative body, one that can be easily accessed and legislators that are willing to discuss health care issues with a nurse constituent. Check the state legislative website: Find out who is your assemblyperson and senator. Contact them and state “I am a registered nurse and would like to provide my expertise in health care, if the need arises”

In the coming election “Term Limits” will require many legislators to step down thereby opening the door for some fresh faces to enter the legislative arena. All assembly seats are up for election and 10 of the 11 senatorial seats are up for election. Would you consider running for office? If not continue to educate yourself, register to vote, support someone whom you believe will make a good legislator. But above all VOTE and make a difference in the direction of the 2009 Nevada legislature and the national arena as well.

Do your part REGISTER and use that four letter word—VOTE
NEVADA NURSES ASSOCIATION MEMBERSHIP APPLICATION
P.O. BOX 34660, RENO, NEVADA 89533 • 775 747-2333 • FAX 775 329-3334

Please mail your completed application with payment to: NNA, P.O. Box 34660, Reno, NV 89533

Please Print Clearly

Last Name/First Name/Middle Initial

Home Phone Number

Cell:

Credentials

Home Fax Number

Basic School of Nursing

Home Address

Work Phone Number

Graduation (Month/Year)

City/State/Zip Code + 4

Work Fax Number

RN License Number/State

County

Position

Email Address

Employer

Would you like to receive NNA email updates with information relative to nursing & healthcare?  YES  NO

Membership Options (Check One)

Full ANA/NNA Membership
(Includes full membership to NNA and the American Nurses Association (ANA) for 12 months.)

F-Full Membership

R-Reduced Membership

_________Employed

_________Not employed

_________Full-time student (must be a RN)

_________New graduate from basic nursing education program, within six months of graduation (first membership year only)

_________New—Never been a member of a state nurses association of the American Nurses Association (first year of membership only)

_________62 years of age or older and not earning more than Social Security allows

S-Special Membership

_________62 years of age or over and not employed

_________Totally disabled

*State nurses' association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense.

State Only NNA Membership
(Includes state only membership to NNA for 12 months. Does not establish membership in the American Nurses Association)

_________Any RN with an active or inactive Nevada license.

*State Only dues must be paid in full at the time of application.

Payment Plan (Check One)

Makes checks out to: NNA/ANA

Full Annual Payment

_________Check (payable to NNA/ANA)

_________Visa

_________MasterCard

Annual Credit Card Payment

This is to authorize annual credit card payments to NNA/ANA. By signing on the line, I authorize NNA/ANA to charge the credit card listed for the annual dues on the 1st day of the month when the annual renewal is due.

Annual Credit Card Authorization Signature*

EDPP (Monthly Electronic Payment)

This is to authorize monthly electronic payments to ANA. By signing on the line, I authorize NNA/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.

Checking: Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.

Credit card: Please complete the credit card information and this credit card will be debited on or after the 1st day of each month.

EDPP Authorization Signature*

*By signing the EDPP or Annual Credit Card authorizations, you are authorizing NNA/ANA to charge the amount by giving the above-signed thirty (30) days advance written notice. Above signed may cancel this authorization upon receipt by NNA/ANA of written notification of termination twenty (20) days prior to the deduction date designated above. Membership will continue unless this notification is received. NNA/ANA will charge a $5 fee for any returned drafts of chargebacks.

To be completed by NNA/ANA

State_________________    District__________

Approved by_________________  Date_________________

Credit Card Information

___________________________________

Bank Card Number and Expiration Date

___________________________________

Authorization Signature

___________________________________

Printed Name

___________________________________

Amount $