The Oklahoma Nurse

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ONA Oklahoma Nurses Association

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The Oklahoma Nurses Association formed 100 years ago on September 1, 1908, a year after statehood. Our organization will celebrate this centennial with various events, memorabilia and commemorative items. An essential element of the centennial is YOU, the community of diverse nurses who make up the membership of ONA. Your experience, knowledge, stories and nursing artifacts will give life and passion to the history we celebrate.

The theme of our annual convention to be held in Tulsa from October 29-31 is 100 Years of Caring, Standing on the Shoulders of Giants. Some individuals are viewed as Giants because they are linked to significant events and milestones. Other individuals are Giants because they impact others to grow, achieve and succeed. Tell us who the Giants are in your nursing journey.

"The Oklahoma Nurses Association is a professional association representing a community of nurses across all specialties and practice settings."

ONA would like to put together some kind of a nursing exhibit to highlight the centennial. A successful exhibit would need photographs, historical documents, uniforms including caps and pins as well as nursing implements. Copies of photographs and documents would be greatly appreciated. Please let us know what you have by calling (405)-840-3476 or emailing ona.ed@oklahomanurses.org.

Commemorative merchandise will soon be available to purchase. A centennial coin is being designed with our current ONA logo on one side and a previous 1908 ONA logo on the other. A T-shirt is also planned. Once ready, you can pre-order these items before the 2008 annual ONA convention or place orders at the convention.

A quilt is a superb metaphor for the ONA. A quilt pieces together seemingly unrelated patterns and fabrics to unite them into an object of practicality and art. Oklahoma nurses are the fabric in the composite quilt of the ONA as evidenced by our mission statement. "The Oklahoma Nurses Association is a professional association representing a community of nurses across all specialties and practice settings." An actual quilt was made years ago to represent the ONA. The centennial is a time to create a new quilt to remember, observe and honor our history. More information will be sent out as this project "comes together". We could unveil the new quilt at the 2009 annual ONA convention to be held in Oklahoma City.

"Nursing as a profession and a career is measured not by years but in moments." (Author Unknown)

Share your historical moments as we mark a significant measure of time. Contact the ONA with your stories, ideas, nursing artifacts and willingness to help with any of the centennial projects planned.

PRESIDENT'S MESSAGE

Standing on the Shoulders of Giants: One Hundred Years of Oklahoma Nurses

This year, the Oklahoma Nurses Association celebrates our 100th year anniversary. We have chosen the theme: "Standing on the Shoulders of Giants" to acknowledge the visionary nurse leaders that formed and sustained our organization, as well as pioneering Oklahoma Nursing.

Recently, we spent time going through the ONA archives, which consist of boxes of pictures, news clippings and other mementos of our professional association. My favorite picture was of Sister Rosella, a past ONA president, holding a string of fish at an ONA function in her full habit! I am sure there is a story to tell, and believe that past boards must have had way more fun at their board meetings that we do today! I look forward to spending the next few months reminiscing about nursing in Oklahoma over that past 100 years. If you have memorabilia you would like to make available for the nursing centennial, let us know. In addition to exploring the relics and artifacts of our professional past, I believe it is important to recognize the contributions made by nurses over the past 100 years.

We have giants of Oklahoma nursing; individuals who have made significant contributions to nursing in our state, as well as nurses that have made significant contributions to nursing at the national and international level. Betty Farrell, international pain management expert began her career in Oklahoma. She was one of my faculty members in graduate school and now she lectures and consults on pain management and end of life care around the world. Other important nursing leaders include Juanita Milsap, founding the first baccalaureate nursing program and Edith Stith Triplett, serving as the first Dean of the University of Oklahoma College, of Nursing. Honoring the nurse leaders of the past century will be an important part of our celebration. In addition, we will have opportunities to honor individuals that have shaped our individual careers.

I am sure many of you have individuals you consider to be your mentors. I have been fortunate to have had several outstanding individuals who have taken an interest in my

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ONA Core Values

ONA believes that organizations are value driven and therefore adopts the following core values.

The Code of Ethics for Nurses
Cultural Diversity
Health Parity
Professional competence
Human dignity and ethical care
Professional integrity
Quality and safe patient care
Commitment to the public health of the citizens of Oklahoma

ONA Mission Statement

The ONA is a professional organization representing a community of nurses across all specialities and practice settings.

Oklahoma Nurse Editorial Guidelines and Due Dates Submittal Information

Materials Due Date to Editor:	***Oklahoma Nurse Issue Date:***
June 15, 2008	September 2008 Issue

1. Manuscripts should be word processed and double-spaced on one side of 8 1/2 x 11 inch white paper. Manuscripts should be emailed to Editor at toneditor@hotmail.com.
   - Manuscripts should include a cover page with the author's name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.
   - Style must conform to the *Publication Manual of the APA*, 4th edition, 1995.
   - *The Oklahoma Nurse* reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.
   - *The Oklahoma Nurse* reserves the right to edit manuscripts to meet style and space limitations.
   - Manuscripts may be reviewed by the Editorial Staff.
2. Photographs should be of clear quality. Black & white photographs are preferred but not required. Write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to:
   Addie Ogunbekun
   Editor, *The Oklahoma Nurse*
   6414 N. Santa Fe, Ste. A
   Oklahoma City, Oklahoma 73116
3. E-mail all narrative to ona@oknurses.com

Contact the ONA

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Oklahoma City, OK 73116

Questions about your nursing license?
Contact the Oklahoma Board of Nursing at 405.962.1800.

Want to advertise in **The Oklahoma Nurse?**
Contact Mark Miller at 800.626.4081 or email at mark@aldpub.com.

Arthur L. Davis Publishing: Excellence in Publication Award

The Arthur L. Davis Publishing Agency proudly announces a $1000 award to be awarded to the ONA Member who submits the 'most excellent' manuscript for publication in *The Oklahoma Nurse*. This Award is offered in celebration of the agency's 24 successful years in publishing and to affirm nursing. The award will be presented at the Awards Banquet and the manuscript printed in a future issue of *The Oklahoma Nurse*.

Manuscript Submission Guidelines:

1. The manuscript must be an original, scholarly work addressing topics of interest to readers of *The Oklahoma Nurse*. Examples of topics: Integrative literature reviews, clinical topics, evolving/emerging professional issues, and analysis of trends influencing nurses and nursing in Oklahoma.
2. Manuscripts must not exceed 15 double spaced pages and must conform to APA guidelines.
3. Manuscripts must be received in an email or diskette as Word Documents by September 1, 2008 to be considered. A cover sheet listing author (s) name, credentials, address, and work and residence telephone numbers and email address must be included. The author (s) name must not appear anywhere else on the submission.
4. The topic must be relevant to nurses/nursing in Oklahoma and provide new insights and/or a contrarian view to promote debate and discussion.
5. Ideas must be supported with sound rationale and adequate documentation.
6. If the manuscript describes a research project, quality initiative, or organizational change process, methods must be appropriate and participant confidentiality protected (as indicated).
7. The manuscript must be grammatically correct, organized, and submitted according to guidelines to be considered.

Manuscripts must be accompanied by a statement signed by each author indicating 1) the manuscript is NOT being considered for publication in any other journal; 2) the manuscript WILL NOT be submitted to another journal until notification of acceptance or rejection is received from the Oklahoma Nurses Association; and 3) willingness to sign a copyright release form upon publication of the manuscript in *The Oklahoma Nurse*.

Submit Manuscripts to the Oklahoma Nurses Association, 6414 N Santa Fe, Ste. A, Oklahoma City, OK 73119 or via email at ona@oknurses.com.

President's Message

(Continued from page 1)

career and provided support and guidance. These individuals have challenged me to try new things, and been honest in their feedback to me. A good mentor will tell you things that no one else will, and provide the critical feedback necessary to foster growth (translation = things you don't always want to hear!). Claudine Dickey, Francene Weatherby and June Schemele are some of my mentors. I am not sure what I would be doing today without their support and encouragement, as well as honest and direct feedback when needed. It is on their shoulders that I stand today! How about you? Do you have individuals you consider to be your mentors? Do they know how much you value their mentorship?

What about those who will be standing on your shoulders? How are you helping them to prepare for the long climb up? Have you identified those who will be taking your place? Do you have a plan to assist the next generation leader to ascend to greatness? Mentoring is one of the most important responsibilities of a profession.

When we look at projections for the nurse shortage, it is clear that we all need to double our efforts in the area of scouting talent, and facilitating emerging leader development. Never before has the need to cultivate others been so important. We are replacing a generation of nurses, and the statistics are not in our favor – the average age of a nurse at the time of graduation is 31. In addition, only 10% of all registered nurses are under 30 years of age. This means we need to be very cognizant of the career track of every nurse, making sure we are providing as many opportunities for development as possible. It also means we must encourage nurses to try new experiences and to develop the confidence necessary to take on new challenges.

I also believe it will be essential to challenge traditional assumptions related to career advancement. These assumptions may be related to the allocation of developmental resources for "middle age" individuals on the premise of a potentially longer career span in the future. As we look at career progression for second career nurses, we will need to figure out how to build on skills of the first. In addition, we will need to become more flexible in our beliefs about how much bedside experience is enough to be prepared for other nursing roles – and believe me, that one may take some work! How much experience is enough?

You have read many times in my columns that this is an exciting time for nurses and nursing. I believe this to be truer now than ever before. I also believe the challenge for us all is to keep cynicism at bay, and focus on the opportunities presented to the nursing profession in the next ten years. For nurses entering the profession, the opportunities are endless! For those of us concerned with the legacy we will leave to our profession, the prospects are also infinite. Here are some thoughts on **the legacy of Boomer and Veteran nurses**:

- Enlist an emerging leader to co-chair every initiative
- Demonstrate the benefits of professional involvement
- Frame issues from a **positive** perspective
- Don't just bring less experienced individuals with you, introduce them
- Help emerging leaders to take on projects incrementally, partner with them
- Break task into manageable pieces, making sure they can be successfully accomplished
- Share the spotlight and the recognition
- Provide the political context to important issues, again in a positive way
- Set the example, be a role model
- Prepare the next generation for the next challenge in health care, develop the skills that will be required in the future – resilience, flexibility and openness to change
- Keep a check on your own emotions related to the healthcare environment of the past, we must prepare emerging leaders for the future!

The centennial year of Oklahoma Nursing give us the opportunity to pay homage to the past and honor our founders. It also gives us the prospect for promoting a positive potential for nursing. Please join me in celebrating our past and future!

Regional Presidents

Region 1:
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Region 2:
President: Jennifer Warren

Region 3:
Diana Mashburn

Region 4:
President: Kay Farrell
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Region 5:
Vacant

Region 6:
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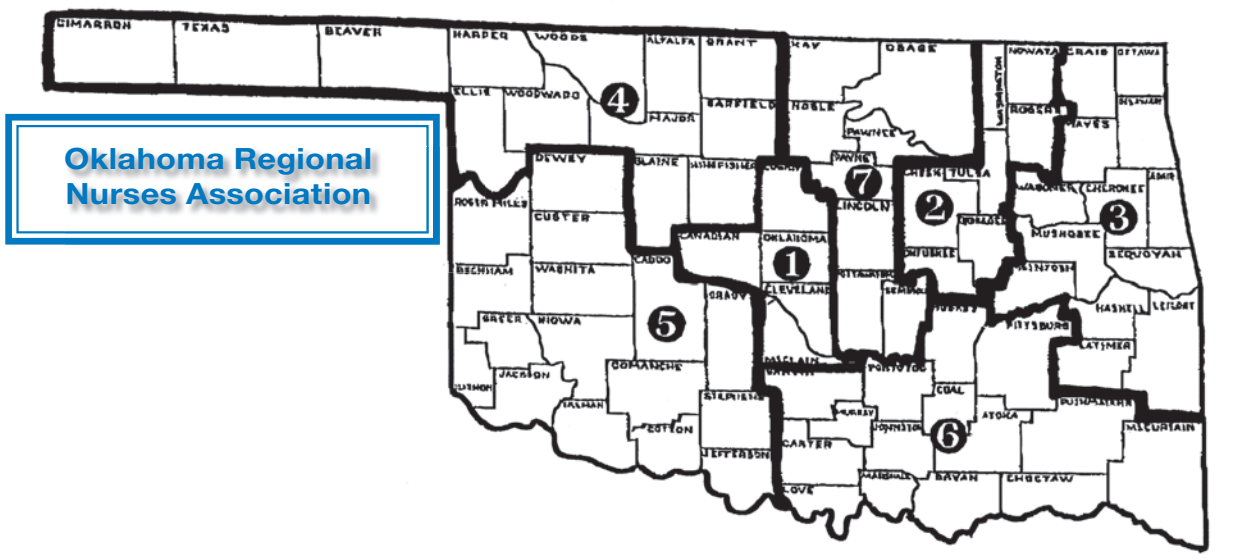
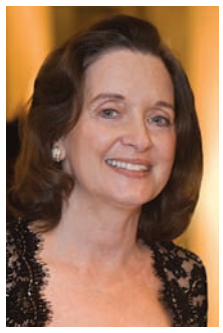
Vacant



ONA News

Obituaries

1948-2008



Dr. Donna Wong

With deep sadness, we share the news of the passing of Dr. Donna L. Wong, 1948-2008. Dr. Donna Wong is internationally renowned for her textbooks on pediatric nursing, *Nursing Care of Infants and Children*, *Clinical Handbook of Pediatric Nursing* and *Essentials of Pediatric Nursing*, all mainstays in nursing education. She served as an instructor, researcher, mentor and consultant in the areas of nursing education, patient care and pain management.

The impact of her research extends well beyond the profession of nursing. The Wong-Baker FACES pain scale - perhaps her most well-known contribution to international health care -reflects her compassion and concern, as well as her innovative approach, in health-care research. This chart of six faces with expressions ranging from happiness to severe pain is a fixture of health clinics around the world, familiar to even the youngest children and their parents.

The University of Oklahoma, where Dr. Wong was an adjunct faculty member in the College of Nursing and in the College of Medicine-Tulsa, raised $250,000 in private funds to establish the Donna L. Wong Professorship of Pediatric Nursing Research in honor of her outstanding career and contributions to nursing. Thanks to generous donors, the College of Nursing reached its goal of $250,000 in 2007. It is important to note that gifts to the Wong Professorship will be maximized through the Oklahoma State Regents Endowment Program, which provides matching funds for endowed faculty positions.

Though Dr. Wong has been honored many times for her work, an endowed professorship in pediatric nursing at University of Oklahoma College of Nursing is just one of many.

Dr. Wong says: "My work is finite, but this endowment offers immortality. Through other gifted and dedicated nurses my efforts to improve the quality of health care for children and their families will continue."

Oklahoma Loses Nursing Leader

Mary McDaniel

With deep sadness, Oklahoma Nurses Association announces the passing of Mary Louise Brents McDaniel, 1927-2008

Mary Louise Brents McDaniel was born May 23, 1927 in Clinton, Oklahoma. As a high school student, She was active in Future Homemakers of America and was a catcher for the Girls Soft Ball Team. She graduated from The Western Oklahoma State Hospital Diploma School of Nursing. Mary was a nurse leader in Oklahoma and worked in several hospitals in the state including Muskogee Regional Hosptial were she worked for 28 years as a Staff Nurse, Head Nurse, Director of Education and Patient Family Educator. Mary retired from MRMC June 1st, 1991.

Mary served as President of the Oklahoma State Nurses Association in 1970-71, and as "Nurse of The Day" at the Capitol numerous times. In 2003, she was honored at the "Five Who Care" celebration where she received the first Lifetime Achievement Award.

Oklahoma Board of Nursing Summary of FY 2007 Annual Report

Mission

The mission of the Oklahoma Board of Nursing is to safeguard the public's health, safety, and welfare through the regulation of nursing practice and nursing education.

Vision

The Oklahoma Board of Nursing gains recognition by all as a model of integrity through legally sound, fiscally responsible, and quality driven decision making and leadership in the regulation of nursing education and practice. Members of the Board are knowledgeable, efficient, and dedicated to the provision of quality services through teamwork, collaboration and creativity.

Values

1. **Our People:** We value the professionalism, dedication and contribution of Board staff, Board members and the professionals who serve on Board committees.
2. **Quality Regulation:** We implement regulatory functions in a consistent, effective and efficient manner.
3. **Quality Education:** We promote preparation for initial licensure and practice through the development of standards for nursing education.
4. **Quality Practice:** We hold nurses accountable for their scope of practice.
5. **Contributions to Public Health Policy Issues:** We collaborate with stakeholders in the development of policies impacting the health, safety and welfare of the public.
6. **Customer Service:** We provide quality customer service to all in a fair and professional manner.
7. **Our Public Image:** We value how we are perceived by the public.

General Functions

1. Prescribe standards for educational programs preparing persons for licensure as a registered nurse, licensed practical nurse, or certification as an advanced unlicensed assistant.
   A. Provide for surveys of nursing education programs according to the rules.
   B. Approve nursing education programs and advanced unlicensed assistant training programs which meet the prescribed standards.

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ONA News

OK Board of Nursing Annual Report (Continued from page 4)

C. Deny or withdraw approval of educational programs for failure to meet or maintain prescribed standards.

2. Administer the National Council Licensure Examination (NCLEX) for Registered and Practical Nurses in accordance with the National Council of State Boards of Nursing, Inc. contract.
3. Administer the advanced unlicensed assistant certification examination in accordance with the contractual agreement with the test service.
4. Provide initial licensure and renewal of licensure of duly qualified applicants, including:
   A. Licensure by endorsement for nurses licensed in other states or educated in foreign countries.
   B. Reinstatement of lapsed license and return to active status applications.
5. Issue/renew certificate of recognition to Advanced Practice Nurses meeting established requirements.
6. Issue/renew prescriptive authority recognition to Advanced Practice Nurses meeting established requirements.
7. Maintain a Peer Assistance Program for nurses whose competency may be compromised by drug abuse or dependency.
8. Investigate complaints of alleged violations of the *Oklahoma Nursing Practice Act and Rules of the Board*.
9. Conduct hearings upon charges calling for disciplinary action.
10. Promulgate rules to implement the *Oklahoma Nursing Practice Act*.
11. Maintain records of all licensed nurses and advanced unlicensed assistants.

Board Members and Staff

The Board is composed of eleven members appointed by the Governor: six Registered Nurses, three Licensed Practical Nurses and two public members. Members serve for a period of five years, except for the public members who serve coterminously with the Governor. The Board employs an Executive Director and defines the duties of the Executive Director. The Executive Director is responsible for the administration of the agency in accordance with the Oklahoma Statutes and the directives of the Board. The agency is authorized for 26 full-time employees.

Records and Reports

The Board maintains records and keeps a list of all licensed nurses. The records of the Board are open to public inspection according to the provisions of the *Open Records Act.*

The State Auditor and Inspector conducts audits of the Board's financial records. A copy of the audit report is provided to the Board and filed with the Publications Clearinghouse of the Oklahoma Department of Libraries.

The Board prepares an annual report of its activities and distributes it to various individuals and groups. A newsletter is distributed two times a year to all active licensed nurses, as well as other interested individuals and groups. The annual report and newsletters are also available to the public on the Board's website: www.ok.gov/nursing.

Budget

The Board does not receive any appropriations of tax money. The licensure fees paid by the nurses in the state constitute the agency's main financial support. The fiscal year 2007 net revenue was $2,531,693.14 and expenses totaled $2,276,013.54.

The Board is required to pay 10% of all fees collected to the Treasury of the State of Oklahoma and these funds are credited to the General fund for appropriation by the legislature to various other agencies and services of state government. The Board paid $265,363.15 to the General Fund in Fiscal Year 2007.

The Oklahoma Nurse Population

The total number of nurses licensed in Oklahoma continues to increase, as shown in the following table:

Nurses Licensed in Oklahoma

	2007 Report		2006 Report		2005 Report		2004 Report	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
RESIDING IN OKLAHOMA								
Employed	25,320	11,960	24,504	12,196	*	*	23,189	12,136
Not Employed in Nursing	3,804	2,983	4,850	3,871	*	*	5,060	3,818
Employment Status Unknown	2,779	1,580	1,391	41	*	*	*	*
Total	31,903	16,523	30,745	16,108	30,496	16,098	29,249	15,954
RESIDING OUT OF STATE								
Employed	3,056	561	3,504	709	*	*	2,330	532
Not Employed in Nursing	765	315	1,553	415	*	*	1,471	414
Employment Status Unknown	1,627	207	4	0	*	*	*	*
Total	5,448	1,083	5,061	1,124	6,514	943	3,801	946
GRAND TOTAL	37,351	17,606	35,806	17,232	37,010	17,041	33,050	16,909

*Data not available

As shown above, only 12% of Registered Nurses and 19% of Licensed Practical Nurses licensed in Oklahoma indicated at the time of renewal that they were not employed in nursing. Approximately 67% of the Registered Nurses residing in Oklahoma who report they are employed in nursing work in hospitals. All other fields of employment trail far behind, with the next highest number of Registered Nurses employed in home health (approximately 7%). Fields of employment for Licensed Practical Nurses are varied, with approximately 30% of Licensed Practical Nurses residing in Oklahoma and employed in nursing reporting employment in long-term care and another 30% reporting employment in hospitals. 84.1% of the Registered Nurses and 85.8% of the Licensed Practical Nurses residing in Oklahoma and employed in nursing work fulltime.

The majority of Registered Nurses in Oklahoma report they hold an associate degree or diploma in nursing (56.1%). Almost 31% report holding a bachelor's degree in nursing and 4.6% report holding a master's degree or doctoral degree in nursing. The average age of Oklahoma Registered Nurses is 46 and of Licensed Practical Nurses is 44. Males represent only 7.6% of Registered Nurses and 5.6% of Licensed Practical Nurses residing in Oklahoma and employed in nursing.

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From L-R Andrea Pogue, Senator Susan Paddack and Lela Luper all of Ada

My Day as "Nurse of the Day"

Andrea L. Pogue, RN, MSN
ONA Member, Government Action Committee Member

I had the great pleasure of serving our state as Nurse of the Day at our Capitol in Oklahoma City, Oklahoma on Thursday March 27, 2008. I brought along a friend that is no stranger to belonging to Oklahoma Nurses Association and serving as Nurse of the Day—Lela Luper, RN, BSN. She works at Valley View Regional Hospital as an Infection Control Nurse. I took the opportunity to reacquaint her with the principle for why we as nurses are an important part of the legislative process.

The day began with a beautiful morning, just simply parking in the lot and walking into the building gave us a great sense of pride. Up the elevator and into the First Aid Care Center located on the 4th floor and seeing the familiar face of Kirk Bass, RN whose job it is to man the station while the capitol workers are in session. He gave us a run down of the latest in coffees and hot teas available to us and began to verbalize some of the House and Senate Bills that are of concern to Oklahoma Nurses. Quickly after, the Sergeant of Arms appeared in the station to take us the House of Representatives so that we could meet with our representatives and be announced as "Nurses of the Day." The entire gallery stood and acknowledged us with applause and pictures as our very own state representative (District 25) Todd Thompson announced our names. It was an awesome feeling that the representatives truly are appreciative of our effort in coming to the capitol. After this, we traveled back to the First Aid Station to meet with Kirk and Vickie White-Rankin (ONA Lobbyist) to develop a battle plan on the day's events.

Soon we were off to the Senate side of the Capitol with the same acknowledgements and accolades by our state senator Susan Paddack. She is the democratic whip for the Senate. Ms. Paddack is a strong supporter of nursing initiatives and promotes better healthcare for rural Oklahomans in her role as a state senator.

This day was filled with serious discussion on topics impacting our state and especially our healthcare system. It is critical that nurses see the importance of serving as "Nurse of the Day" and make contact with key legislators in keeping bills that are important to quality healthcare alive through committees and pushed to successful resolution.

It is truly an amazing experience; all ONA members should feel the excitement to serve as an Oklahoma Nurse.

ONA News

Oklahoma Nurses Association Endorses LTC Financial Partners, LLC (LTCFP) to Provide Long-Term Care Education and Insurance

Oklahoma City, OK—Oklahoma Nurses Association (ONA) will begin making Long-Term Care education and insurance available to its nurses, employees of the association and their families.

"After an extensive search, we've entered into an arrangement with LTC Financial Partners, LLC" said Executive Director, Jane Nelson. "Through this arrangement, LTC Financial Partners will provide our nurses and their families with superior Long-Term Care education and access to discounted rates for Long-Term Care insurance plans. Employees actively at work may qualify for simplified health underwriting for a limited time in addition to discounted rates."

"Long-Term care costs are an expense that can directly threaten the financial security and independence of an individual and their extended family, particularly in retirement," stated Nelson.

Long-term care is becoming an increasingly important consideration as the American population ages. According to the U.S. Department of Health and Human Services, more than 60% of seniors over age 65 will need some type of long-term care. This year, that number is expected to be more than nine million Americans. By 2020, it could exceed 12 million.

LTC Financial Partners, LLC is one of the country's most experienced long-term care organizations, specializing in educating and empowering consumers about long-term care issues. With offices nationwide, they offer face-to-face or telephone counseling and advice to individuals and employers regarding their specific long-term care financing needs. They are committed to helping people live life fully and completely in dignity, comfort and independence without financial burden.

(LTCFP) will launch the new program immediately. Specific details about the program will be shared directly with ONA participants based upon a phased implementation plan.

OK Board of Nursing Annual Report (Continued from page 5)

Licensure by Examination

In the last five years, the number of first-time testers who were educated in Oklahoma has increased significantly. The numbers in the next two tables include any tester educated in Oklahoma, applying for licensure in any state. It is anticipated that this number will continue to grow as nursing education programs expand to meet the need for more licensed nurses.

Registered Nurse (RN) Licensure Examination Statistics (First Time Oklahoma-Educated Writers by Calendar Year)*

	CY2002	CY2003	CY2004	CY2005	CY2006	1 & 5 Year Variance
Number of Candidates	1,057	1,122	1,311	1,447	1,772	↑22.5%/↑67.6%
Oklahoma Pass Rate	83.92%	86.36%	83.68%	86.59%	88.88%	↑2.6%/↑5.9%
National Pass Rate	86.66%	87.01%	85.26%	87.29%	88.11%	↑0.9%/↑1.7%

*Includes Oklahoma-educated candidates applying for licensure in other states

Licensed Practical Nurse (LPN) Licensure Examination Statistics (First Time Oklahoma-Educated Writers by Calendar Year)*#

	CY2002	CY2003	CY2004	CY2005	CY2006	1 & 5 Year Variance
Number of Candidates	1,077	1,168	1,160	1,260	1,267	↑0.5%/↑17.6%
Oklahoma Pass Rate	86.07%	89.21%	91.81%	90.95%	88.95%	↓2.2%/↑3.3%
National Pass Rate	86.5%	88.21%	89.36%	89.06%	87.87%	↓1.3%/↑1.6%

*Includes Oklahoma-educated candidates applying for licensure in other states

#Included in the NCLEX-PN figures in the chart are PN equivalency candidates. Students who are enrolled in RN education programs are eligible to apply to take the NCLEX-PN examination as equivalent candidates after completion of specified course work. In addition, certain military medics may apply to take the NCLEX-PN examination as special candidates.

New Licenses Issued By Examination

Level of Licensure	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 Year Variance
Registered Nurse	1,133	1,216	1,239	1,527	1,567	↑2.6%/↑38.3%
Licensed Practical Nurse	1,006	997	1,205	1,187	1,210	↑1.9%/↑20.3%
TOTAL	**2,139**	**2,213**	**2,444**	**2,714**	**2,777**	**↑2.3%/↑29.8%**

New licenses issued by examination for RNs continue to demonstrate a significant increase over the past five years, but the increase has slowed over the past year, verifying the continued need to focus on recruitment into the nursing profession and improving NCLEX pass rates.

Licensure by Endorsement

The Board may issue a license to practice without examination to any applicant who has been duly licensed as a registered nurse or licensed practical nurse, or is entitled to perform similar services under a different title, according to the laws of another state, territory, the District of Columbia, or a foreign country, if such applicant meets the requirements for licensure in the State of Oklahoma. Applications for RN licensure by endorsement have increased dramatically over the past five years, as shown in the following table:

Initial Applications for Licensure by Endorsement

Level of Licensure	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 Year Variance
Registered Nurse	637	851	1,011*	1,899*	1,931	↑1.6%/↑203.1%
Licensed Practical Nurse	146	195	212*	187*	257	↓37.4%/↑76%
TOTAL	**783**	**1,046**	**1,223***	**2,086***	**2,188**	**↑4.8%/↑179.4%**

*Corrected figures

A certified verification of licensure is requested by a state or country when a nurse applies for licensure by endorsement in that state or country. Although the Board does not receive notification that a nurse has applied for licensure in another state, the number of verifications requested provides a rough estimate of the number of nurses who have applied for licensure in other states and/or countries; however, it must be noted that the nurse may still continue to retain his/her license in Oklahoma and work, even when holding a license in another state. Further, because most boards of nursing require a certified verification of licensure from the original state, nurses who left the state many years ago and whose licenses are lapsed are included in the number identified in the following table:

Number of Endorsement Verifications to Other States

Level of Licensure	FY2003	FY2004	FY2005	FY2006	FY2007	1&5 Year Variance
Registered Nurse	1,396	1,437	1,782	1,784	1,968	↑10.3%/↑40.9%
Licensed Practical Nurse	480	514	499	560	438	↓27.8%/↓9.5%
TOTAL	**1,876**	**1,951**	**2,281**	**2,344**	**2,406**	**↑2.6%/↑28.2%**

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ONA News

OK Board of Nursing Annual Report (Continued from page 6)

Advanced Practice Recognition

The *Oklahoma Nursing Practice Act* establishes four types of advanced practice nurses: (1) Advanced Registered Nurse Practitioner [ARNP]; (2) Certified Nurse Midwife [CNM]; (3) Clinical Nurse Specialist [CNS]; and (4) Certified Registered Nurse Anesthetist [CRNA].

Number of Advanced Practice Nurses Recognized in Oklahoma

Type of Recognition	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 Year Variance
ARNP	626	648	687	93	731	↑5.4%/↑16.7%
CNM	37	42	45	41	46	↑12.1%/↑24.3%
CNS	183	190	198	172	186	↑8.1%/↑1.6%
CRNA	414	437	472	499	511	↑2.4%/↑23.4%
TOTAL	**1,260**	**1,317**	**1,402**	**1,405**	**1,474**	**↑4.9%/↑16.9%**

The total number of advanced practice nurses recognized in Oklahoma continues to show a steady, although small, increase.

Advanced Practice Nurses may apply for prescriptive authority, after meeting educational requirements.

Number of Advanced Practice Nurses with Prescriptive Authority

Type of Recognition	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 Year Variance
ARNP	441	*539	531	518	543	↑4.7%/↑23.1%
CNM	23	*21	26	25	28	↑12%/↑21.7%
CNS	47	*53	51	56	63	↑12.5%/↑34%
CRNA	78	*91	94	89	104	↑16.8%/↑33.3%
TOTAL	**589**	***704**	**702**	**688**	**738**	**↑7.2%/↑25.2%**

*Corrected number from 2004 report.

Approximately half of advanced practice nurses seek prescriptive authority recognition, similar to the percentage seeking prescriptive authority in FY2003.

Certification of Advanced Unlicensed Assistants

Advanced Unlicensed Assistive Personnel (AUAs) complete a 200 hour training program, which is designed to build upon basic skills traditionally performed by nursing assistants working in health care settings. A list of Board-approved AUA training programs is available on the Board's website: www.ok.gov/nursing. Specific core skills, legal and ethical aspects of health care and appropriate personal behaviors are presented in a format that combines classroom lecture/discussion, demonstration/practice lab and clinical application. Upon satisfactory completion of the course work, graduates of these training programs are eligible to take the AUA certification examination. This examination is developed by Oklahoma Department of Career and Technology Education and is approved by the Oklahoma Board of Nursing. Upon successful completion of the certification examination, the Board-certified AUA may perform the skills that are identified on the *Approved Skills List for Performance by Board-Certified Advanced Unlicensed Assistants*, under the supervision of Registered Nurses and Licensed Practical Nurses in acute care settings.

Advanced Unlicensed Assistants

Certifications	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 Year Variance
# New Certifications	118	101	125	162	123	↓31.7%/↑4.2%
Total # AUAs Certified	396	496	546	584	593	↑1.5%/↑49.7%

The number of individuals holding AUA certification continues to increase, but the increase has slowed and the total number remains small.

Nursing Practice/Advanced Nursing Practice (APN) Activities

The Oklahoma Board of Nursing is charged with providing information on the *Oklahoma Nursing Practice Act and Rules of the Board,* coordinating nursing practice activities, collecting and analyzing data related to nursing practice issues and the nursing population to identify trends and future needs, and studying the impact of legislation and rules on nursing practice. The following report summarizes nursing practice activities in FY 2007.

For FY2007, there were 89 written responses to practice related issues, as compared to 101 responses in FY 2006. Although there was a 12% decrease in the number of letters this fiscal year, the complexity of the questions and research conducted to complete the responses have increased. Practice letters primarily were from employers in medical centers and from individual nurses in both fiscal years. During FY2007, there were 1,049 practice visits and calls documented, as compared to 1,108 in FY2006.

The following practice related Board documents were developed [new], revised or reviewed without revision or rescinded this fiscal year:

1. *Delegation of Nursing Functions to Unlicensed Persons*, #P-02 – [**Revised 07/06**]
2. *Licensure Verification and Photocopying of Nursing Licenses*, #A-05 – [**Revised 07/06**]
3. *Position Statement on Entry into Practice* – [**Reviewed without revision 07/06**]
4. *School Nurse Position Statement* – [**Reviewed without revision 07/06**]
5. *Patient Assessment Guidelines*, #P-14 – [**Revised 07/06**]
6. *Issuance of Temporary Licenses for RNs and LPNs*, #P-09 – [**Revised 07/06**]
7. *Request for Inactive Status Policy*, #P-08 – [**Rescinded 07/06**]
8. *Agency Policy on Names*, #A-06 – [**Revised 07/06**]
9. *National Certifying Bodies Approved by the Oklahoma Board of Nursing Policy*, #P-52 – [**Rescinded 09/06**]
10. *National Certifying Bodies and **APN Certification Examinations** Approved by the Oklahoma Board of Nursing Policy*, #P-52A – [**New 09/06**]
11. *National Certifying Bodies and **Non-APN Certification Examinations** Approved by the Oklahoma Board of Nursing Policy*, #P52-B – [**New 09/06**]
12. *National Certifying Bodies and **APN Certification Examinations** Approved by the Oklahoma Board of Nursing* # P-52-A - [**Revised 09/06**]
13. *Approval of Advanced Practice Educational Programs*, #P-51 – [**Revised 11/06**]
14. *Advanced Practice Nurses with Prescriptive Authority Exclusionary Formulary*, #P-50B – [**Reviewed without Revision**]
15. *Board Document Definitions Policy*, #P-20 – [**New 11/06**]
16. *Abandonment Statement*, #P-11- [**Reviewed without Revision**]
17. *Licensure Requirements for Provision of Nursing Care by Telecommunications/Electronic Communications Position Statement*, #P-16 - [**Reviewed without Revision**]
18. *A Decision Making Model for Determining RN/LPN Scope of Practice – Model for Scope for Nursing Practice Decisions*, #P-10 – [**Revised 05/07**]
19. *National Certifying Bodies and **APN Certification Examinations** Approved by the Oklahoma Board of Nursing*- #P-52A - [**Revised 05/07**]
20. *CRNA Inclusionary Formulary* - #P-50A - [**Revised 05/07**]
21. *Laser Hair Removal Treatment - Declaratory Ruling* – [**New 05/07**]
    05/06 *CRNA Inclusionary Formulary*, #P50A - **Reviewed without revision**

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ONA News

OK Board of Nursing Annual Report (Continued from page 7)

Education Activities

The Oklahoma Board of Nursing holds the responsibility for setting nursing education standards and conducting survey visits to programs to ensure standards are met. The Board reviews and approves requests for new programs and program changes. The Board further maintains records verifying faculty qualifications and collects data on program, faculty and student characteristics.

Oklahoma's technology centers, private vocational schools, community colleges, and universities have responded to the nursing shortage by increasing the number of programs, campuses, and enrolled students, as shown in the following tables:

Number of Nursing Education Programs

Types and Numbers of Programs	FY2003	FY2004	FY2005	FY2006	FY2007
# Baccalaureate Programs/Campuses*	11/17	11/17	11/16	12/18	13/20
# Associate Degree Programs/Campuses	15/22	16/25	17/26	18/31	18/31
# Practical Nursing Programs/Campuses	31/49	31/49	30/49	30/50	30/47
TOTAL	**57/88**	**58/91**	**58/91**	**60/99**	**61/98**

*RN-BSN not included

Student Enrollment in Nursing Education Programs

Type of Program	FY2003	FY2004	FY2005	FY2006	FY2007	1 & 5 year variance
Baccalaureate Degree*	1,253	1,553	1,599	1,926	2,191	↑13.7%/↑74.9%
Associate Degree	2,158	2,221	2,655	2,708	2,875	↑6.2%/↑33.2%
Practical Nursing	2,323	2,424	2,328	2,396	2,477	↑3.4%/↑6.6%
TOTAL	**5,734**	**6,198**	**6,582**	**7,030**	**7,543**	**↑7.3%/↑31.5%**

*RN-BSN not included

Enrollments at all levels of nursing education continue to increase, with the highest percent increase noted at baccalaureate nursing education, reflecting the strides nursing education programs have taken to meet the demand for licensed nurses over the past several years. The recent report published by the Governor's Council on Workforce and Economic Development recommends that even higher enrollments will be necessary through 2012 to meet the anticipated demand for nurses. This will continue to challenge nurse educators to find funding, physical facilities, qualified faculty, and clinical space to educate these students.

The following Board documents related to nursing education were developed [new], revised or reviewed without revision, or rescinded this fiscal year:

1. *Establishing Training Equivalency for Certification as an Advanced Unlicensed Assistant Policy*, #E-41 [**Revised 7/06**]
2. *Completing the Certification Examination as an Advanced Unlicensed Assistant Policy*, #E-40 [**Rescinded 7/06**]
3. *Nursing Education Programs with Extended and Multiple Campuses Policy*, #E-03 [**Revised 7/06**]
4. *Guidelines for Nursing Education Programs Offering Non-Traditional Learning Options*, #E-08 [**Revised 7/06**]
5. *Guidelines for Individuals Enrolled in or Non-Licensed Graduates of Nursing Education Programs*, #E-04 [**Revised 3/07**]

In addition, Board staff conducted survey visits to 16 nursing education programs and reviewed NCLEX pass rate reports submitted by 13 nursing education programs. The Board made recommendations for action based on the findings of the survey visit and pass rate reports. The Board approved requests for curriculum changes made by seven programs and approved extended campus offerings requested by three programs.

Investigation/Discipline

The *Oklahoma Nursing Practice Act* (ONPA) gives the Oklahoma Board of Nursing (Board) the power to 1) deny, suspend, or revoke any license to practice registered nursing or licensed practical nursing, or recognition for practice as an advanced practice nurse, or certification as an advanced practice nurse, or certification as an advanced unlicensed assistive person; 2) assess administrative penalties; or 3) otherwise discipline a licensee or advanced unlicensed assistive person. Board staff, legal counsel, and/or other governmental agencies complete investigations of nursing practice incidents reported to the Board. During any investigation, the staff emphasizes the Board's commitment to the due process afforded each individual under the provisions of the *Oklahoma Nursing Practice Act* (ONPA) and the *Administrative Procedures Act* as well as the Board's legislative mandate to safeguard the public's health, safety, and welfare.

The number of nursing practice incidents reported to the Board during FY2007 that resulted in opened cases for investigation and consideration for discipline by the Board increased 21% compared to FY2006. The rate of complaints received is calculated by dividing the number of individual licensed nurses who were subjects of complaints during 2007 by the total number of active licensees in the state. The rate of complaints received during FY2007 was 10.1 per 1000 nurses (or 1.01% of total number of active licensees in the state).

Cases Opened—Classification of Licensure/Certification/Applicant

FY2007	RN	LPN	RN Endors.	LPN Endors.	NCLEX -RN	NCLEX-PN	APN	AUAP	Other	Total
Number	311	356	11	7	10	17	9	1	0	722
Percent	43%	50%	2%	1%	1%	2%	1%	0%	0%	100%

Type of Cases Opened

FY2007	Drug	Nursing Practice	Abuse/ Neglect	Felony	Board Order Violation	*Other	Reinstatement/ Return to Active	Fraud	Worked Lapsed License	Total
Number	174	245	50	23	15	154	31	15	15	722
Percent	24%	34%	7%	3%	2%	22%	4%	2%	2%	100%

*Other types of administrative procedure cases were: hearing on temporary suspensions, request to amend, request to terminate probation, request for inactive status, voluntary surrender or court order surrender of license, misdemeanor, reappear before the Board as ordered, peer assistance related, request for reconsideration of Board decision, lawsuit, renewal application, etc.

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ONA News

OK Board of Nursing Annual Report (Continued from page 8)

Location of Cases Opened

FY2007	Hospital	Nursing Home	Home Health	*Other Nursing	**Other Non-Nursing	Total
Number	143	269	30	65	215	722
Percent	20%	37%	4%	9%	30%	100%

*Other nursing settings are physician's office, clinic, hospice, state correction facility, etc.
** Other non-nursing settings are felonies, reinstatements, probation violations, etc.

The Board takes actions on open cases involving respondents or applicants in order to protect the health, safety, and welfare of the public. Those actions include denying licensure/certification (for example upon renewal, application for endorsement, application for licensure/certification by examination, or reinstatement), revoking, suspending or otherwise disciplining a licensee or an advanced unlicensed assistive person. Many times the Board renders multiple types of action to a respondent or applicant, e.g., probation and requiring educational courses.

Peer Assistance Program

A Peer Assistance Program (PAP) was implemented in November 1994 under the supervision and control of the Board of Nursing. The program is a voluntary alternative to formal disciplinary action whose purpose is to assist in the rehabilitation of licensed nurses who have abused drugs and/or alcohol. This approach allows the Board to retain control of nursing practice for the protection of the public.

As a part of the Board's oversight, it approves the program guidelines and periodically reviews and revises those guidelines. In FY2007 the Board approved revisions to the program's *Body Fluid Testing Guidelines; Laboratory Approval Criteria for Body Fluid Testing; Psychiatric-Substance Evaluation Criteria; Supervised Practice Guidelines; Requests to Return to Work in Positions Providing Increased Autonomy and/or Limited Supervision Guidelines; Confidentiality Policy and Committee Member Appointment Criteria.* The Board also approved the *Peer Assistance Committee Code of Conduct*.

Committee members are appointed by the Board of Nursing for a three-year term and serve voluntarily without pay. The 24 individuals serving on committee in FY2007 each averaged 55 hours in committee meetings (not including preparation time for the meeting). This is the equivalent 7 workdays each of service work to the program.

Nurses enter the program voluntarily either through direct application or referral from the Board of Nursing. The minimum length of participation in the program for successful completion is 24 months with a maximum of 5 years. The average length of participation for individuals successfully completing the program during FY2007 was 29 months.

Termination from the program can occur anytime after acceptance into the program. The average length of participation for individuals terminating from the program in FY2007 was 9 months. Twenty-six (43%) of the 61 individuals terminated from the program were in the program 3 months or less. The majority (75%) of individuals terminated from the program had less than one year's participation and 54% were in for less than 6 months.

All nurses entering the program

FY	2003	2004	2005	2006	2007	5-year Totals	Yearly Average	Variance 1 year	5 year
Participants On 6/30	105	139	156	135	148	683	137	10%↑	41%↑
Participants Discharged	23	17	28	47	34	149	30	28%↓	48%↑
Participants Terminated	40	45	44	65	61	255	51	6%↓	52%↑
Total Participants	168	201	228	247	243	1087	217	2%↓	45%↑
Applicants not entering	28	20	14	23	21	106	21	9%↓	25%↓
***Total Cases**	**196**	**221**	**242**	**270**	**264**	**1193**	**239**	**26%↓**	**35%↑**

(*Total cases are the number of participants in the program during the year plus the number who went through the application process and then did not sign a contract with the program.)

Nurses referred to the program through Board Action account for: 55% of the nurses entering the program in the last 5 years, 60% of those terminated from the program and 56% of those successfully completing the program.

Nurses referred to the program without Board Action account for: 45% of those entering the program in the past 5 years, 40% of those terminated from the program and 44% of all the nurses who successfully completed the program in the last five years.

Summary

The Oklahoma Board of Nursing members and staff work hard to safeguard the public's health, safety and welfare through the regulation of nursing practice and nursing education. For more information on the activities of the Oklahoma Board of Nursing and the nurse population in Oklahoma, please access the Board's website: www.ok.gov/nursing. A full copy of the annual report is posted on the website under "Publications." Copies of the Board's newsletters can also be found under that link. Copies of many commonly requested guidelines, declaratory rulings, and other documents can also be found on the website.

ONA Convention

Oklahoma Nurses Association Recognizing Excellence In Nursing...

The Oklahoma Nurses Association has many members whose outstanding contributions should be recognized. The following award categories have been established to recognize excellence in Oklahoma Nursing:

EXCELLENCE IN NURSING
NURSING RESEARCH AWARD
NURSING IMPACT ON PUBLIC POLICY AWARD
NIGHTINGALE AWARD OF EXCELLENCE
FRIEND OF NURSING AWARD
EXCELLENCE IN THE WORKPLACE ENVIRONMENT

ELIGIBILITY

Nominees for ONA awards must meet specific criteria. These individuals must be ONA members, except for the Friend of Nursing Award, which is given to a non-nurse or for the WPA Excellence in the Workplace, which is presented to organizations. Members of the ONA Board of Directors and the Awards Selection Committee are not eligible for ONA awards during the period in which they serve in these capacities.

PROCEDURE AND GENERAL INFORMATION

1. Nominations may be submitted by an individual, association, committees, regional nurses associations, nursing education programs, organized nursing services or the Oklahoma Board of Nursing.
2. Nominees Practice area may be in any service setting: education, primary care, legal, consulting, nurse entrepreneur, public policy, or any area in which professional nurses practice.
3. All nominations must be submitted on the appropriate Nomination Form and all requested information must be provided. Electronic submission preferred.
4. Materials required for nominations include the following:
   a. completed nomination form
   b. nominator's narrative statement (described below)
   c. brief curriculum vitae and any additional pertinent information (not required for the Friend of Nursing award nominations)
   d. two letters supporting the nomination, such as a supervisor or colleague
5. The narrative statement should detail the accomplishments of the nominee and be presented concisely. It is this narrative statement, which is weighed most heavily in the selection process.

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ONA Annual Convention

2008 Call For Presentations

Concurrent Sessions

October 30 & 31, 2008

The ONA convention committee is seeking presentations for the 2008 ONA Convention, October 29—30. These concurrent sessions will be on October 30 and 31. Our audience for the ONA Convention includes all facets of nursing, from direct care nurses to entrepreneurial nurses and nursing students.

Presentations are encouraged on the following topics: leadership; shared governance; healthy work environments; Magnet; generational issues; diversity; workplace issues; nursing resources; communication skills; staffing; nurses responsibility and fatigue; pain management; nurse entrepreneurs; alternative methods; best practices; disease states; balancing life; innovations in nursing, technology-providing tools for change; and the mature experienced nurse.

This opportunity to present a concurrent session, provides you with the opportunity to share your expertise, best practice, research findings or experience with your colleagues and students about important issues facing the nursing profession as well as healthcare issues. Both nursing professionals and nursing students are encouraged to participate.

Submission:

- Abstracts of 200-500 words are to be submitted typewritten, single spaced on an 8 1/2 X 11 sheet of paper, with a font size of at least 10 point or greater. A face sheet is to be attached and should include:
  *title of abstract
  *educational objectives...these should be behavioral, measurable and learner outcome statements
  *name of author(s) and credentials. If multiple authors, indicate name and address of the author who is to serve as the contact person. Authors may submit more than one abstract for consideration, but all abstracts must be accompanied by a separate cover sheet.
- CNE Packet-available on the ONA website, www.oklahomanurses.org, includes:
  *Biographical Form
  *Presenter's Declaration Form
  *Educational Objective Form
  *Audiovisual Requirements

Abstracts and supporting information must be submitted via e-mail or on disk to:

Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, OK 73116
ona@oklahomanurses.org
405.840.3476 Fax: 405.840.3013

Deadline:
Submission must be postmarked by **July 1, 2008,** The first author will be notified of the review committee's decision no later than **August 1, 2008**.

ONA Convention

2008 ONA Annual Convention Oct 29 - 31, 2008

Call for Poster Abstracts

The ONA Poster Session provides an opportunity to present research and innovative nursing programs or nursing issues using charts, graphs, illustrations and narrative. By participating in the Poster Session you will have an opportunity to share nursing success, encourage discussion as well as network with others. ONA encourages all nursing professionals, including students across Oklahoma, to consider submitting poster presentations highlighting any project related to a successful or innovative practice, process improvement, Evidence Based Practice, administration, education, clinical or research in nursing. Students (undergraduate or graduate) are also encouraged to submit their research projects as well. Posters will be displayed on October 30.

SUBMISSION:

Abstracts of 100-300 words are to be submitted typewritten, single-spaced on an 8 1/2 X 11 sheet of paper, with a font size of at least 10 point or greater. A face sheet is to be attached and should include:

- Title of abstract
- Name of author(s) and credentials. If multiple authors, indicate name and address of the author who is to serve as the contact person. Authors may submit more than one abstract for consideration but all abstracts must be accompanied by a separate cover sheet. Abstracts and supporting information may be submitted via e-mail, fax or postal mail.
- CNE Packet must also be submitted-available on the ONA website, oklahomanurses.org, includes:
  - *Biographical Form
  - *Presenter's Declaration Form
  - *Educational Objective Form

Deadline:

Submission must be postmarked by August 1, The first author will be notified of the review committee's decision by August 15.

ONA OKLAHOMA NURSES ASSOCIATION

Oklahoma Nurses Assn.
6414 N. Santa Fe, Suite A
Oklahoma City, OK 73116
ona@oklahomanurses.org
405.840.3476
FAX 405.840.3013

ONA Recognizing Excellence in Nursing

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6. Nominations and attached materials will be treated in a confidential manner.
7. Incomplete nominations will be declined.
8. Awards will be presented at the ONA convention on Friday. Recipients will be invited to attend the presentation of the award. If, because of extenuating circumstances, a recipient cannot be present, the presentation will be made in absentia.

DEADLINE FOR SUBMISSION

The deadline for submission of nominations is **August 1**. Mail completed forms and supporting materials to:

Awards Selection Committee
Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, Oklahoma 73116

EXCELLENCE IN NURSING

The *Excellence in Nursing Award* is conferred on a member, who has developed an innovative, unique and creative approach that utilizes nursing theory and knowledge/skills in any practice setting: Administration, Education, and/or Direct Patient Care. The recipient should be recognized by peers as a role model of consistently high quality nursing practice and as one who enhances the image of professional nursing by creating an environment promoting professional autonomy and control over nursing practice.

NURSING RESEARCH AWARD

The *Nursing Research Award* recipient is a nurse who has made a significant impact on nursing practice through the use of research as a basis for practice innovation. Significant impact on nursing practice means that the nurse has contributed to the creation of new nursing knowledge through research findings; and has improved or created a plan for improving clinical nursing practice and/or patient outcomes in response to the findings.

NURSING IMPACT ON PUBLIC POLICY

Nursing Impact On Public Policy Award honors the nurse, whose activities are above and beyond those of the general nursing community to further the political presence of nursing and/or to accomplish positive public policy for the nursing profession.

NIGHTINGALE AWARD OF EXCELLENCE

The *Nightingale Award of Excellence* is conferred on an ONA member who during their career has:

- Demonstrated innovative strategies so as to fulfill job responsibilities and/or role responsibilities in their professional role and within the community they work and live.

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ONA Convention

ONA Recognizing Excellence in Nursing

(Continued from page 11)

- Consistently surpass expectations of a professional nurse; thus enhancing the image of nursing as a profession.
- Demonstrates sustained and substantial contribution to the Oklahoma Nurses Association.
- Served as a role model of consistent excellence in their area of practice.

Other professional behaviors, such as mentoring, advocacy, research conduction or utilization, publications and presentations should also be demonstrated throughout his/her career.

FRIEND OF NURSING

The *Friend of Nursing Award* is conferred on non-nurses who have rendered valuable assistance to the nursing profession. Their contributions and assistance are of statewide significance to nursing.

EXCELLENCE IN THE WORKPLACE ENVIRONMENT

The *Excellence in the Workplace Environment Award* is presented to organizations that have developed positive work environments. These organizations must have developed an Innovative and effective program, approach or overall environment that promotes excellent nursing care, creating a positive environment for nurses to work and supports nurses in their practice. (Please note that this designation is for a five year period of time. After five years, facilities may re-apply)

Please include the following information with your nomination:

Name of Facility

Address of Facility

Supervising Nurse

Phone Number

Description of the positive organizational culture and how it promotes excellent nursing care, creates a positive environment for nurses to work and supports nurses.

Send your nomination to the ONA Office

Mail: ONA, 6414 N. Santa Fe, Suite A, Oklahoma City, OK 731116

FAX: 405-840-3013

EMAIL: ona.ed@oklahomanurses.org

OKLAHOMA NURSES ASSOCIATION AWARD NOMINATION FORM

Please use for the EXCELLENCE IN NURSING •NURSING RESEARCH •NURSING IMPACT ON PUBLIC POLICY •NIGHTINGALE AWARD OF EXCELLENCE •FRIEND OF NURSING

Please print or type all information. Only completed nominations will be considered.

Name of the Award _____

Nominee's Name_____

Credentials (please abbreviate) _____

Home Address _____

City/State/Zip _____

Home Phone (___) _____

Employer's Name _____

Title/Position_____

Employer's Mailing Address _ _____

City/State/Zip _____

Business Phone (___) _____

Nomination Submitted by _____

Mailing Address _____

City/State/Zip _____

Day Phone (___) _____

Information attached: _____ Narrative Statement (detail contributions)

_____ Curriculum Vita (except Friend of Nursing Award nominees)

_____ Two letters supporting nomination

Signature _____ Date _____

Mail to: Oklahoma Nurses Association
6414 N. Santa Fe, Suite A
Oklahoma City, Oklahoma 73116

Deadline for submission of nominations is August 1.

Oklahoma League for Nursing
An affiliate of the National League for Nursing and Oklahoma Nurses Association 2007-08 Affiliate Report

The Oklahoma League for Nursing (OLN) has full approval as a constituent affiliate of the National League for Nursing, and has continued affiliate status with the Oklahoma Nurses Association for another year. The OLN focuses on nursing education at all levels and practices, e.g., formal and continuing education, and staff development.

OLN approved Marie Ahrens as the OLN Consultant to the Oklahoma Nursing Student Association for the past year. Thea Clark represented OLN at the ONA convention. Thea Clark is the Treasure of IONE, Institute for Oklahoma Nurse Educators.

One continuing education offering is being co-sponsored by OLN this year. This is the Oklahoma Health Care Workforce Center's Best Practices workshop Part II on May 21, 2008. OLN is open to further co-sponsorship opportunities.

Three awards were given to one NLN affiliated school from each level of education. These awards were to be used for faculty development, preferably using NLN services or products. The awards were given to Northwestern Oklahoma State University, Rose State College and Southern Oklahoma Technology Center.

Elections held in October 2007 resulted in the following: Thea Clark was asked to remain in office for a second term. There is no President Elect currently. Anne Davis was elected secretary. Marie Ahrens continues in office as treasurer.

Information about NLN educational offerings have been shared via meetings and email. Information regarding certification as a Certified Nurse Educator by the National League for Nursing was also shared. At this time there are 38 educators in Oklahoma that have been awarded the Certified Nurse Educator (CNE) designator.

Currently we have 34 members in the OLN. All Oklahoma nurses are invited to join OLN for only $15 per year. Applications were mailed, e-mailed, and distributed at various statewide meetings.Funds directly support the co-sponsored continuing education offerings and educational awards to affiliated schools. For an application contact me at thea.clark@tulsatech.org

Submitted by Thea Clark MS, RN
President of the Oklahoma League for Nursing
Coordinator School of Practical Nursing
Tulsa Technology Center
3420 S. Memorial Drive
Tulsa, Oklahoma 74145
918/828-1213
Thea.clark@tulsatech.org

ONA Convention

ONA Convention Official Call to the Delegates To Attend a Meeting Of the ONA House of Delegates in Tulsa, OK

Thursday, October 30, 2008, at 4:15 p.m. and Friday, October 31, 2008 at 3:00 p.m. (if necessary)

From—Linda Lyons-Coyle, RN, MSN
ONA Secretary/Treasurer

This notice constitutes the official call to meeting of the Meeting of the ONA House of Delegates. The House session will be held Thursday, October 30, 2008, and Friday, October 31, 2008 in Tulsa, Oklahoma. The House of Delegates will convene at 4:15 p.m., Thursday. The representation of each Regional Nurses Association established for the 2008 House is as follows:

The ONA House of Delegates is composed of member nurses duly elected through secret ballot by constituent regional members. The House of Delegates also provides a courtesy seat to Past ONA Presidents and one registered nurse participant from each organizational affiliate.

Each delegate must study the issues thoroughly, attend the Town Hall meeting and other informational sessions, engage in open-minded debate, practice active listening and use the extensive resources and collective knowledge made available throughout the meetings to assist them in making informed decisions. Members of the ONA House of Delegates are elected through a regional election process and have a crucial role in providing direction and support for the work of the state organization. They come to the House to work towards the growth and improvement of ONA and its constituencies. This requires a professional commitment to the preservation and creative growth of the professional society at all levels of the organization. Such a commitment will benefit the individual delegate, the Association and the nursing profession.

If you are interested in having an issue considered by the ONA House please submit a reference to be heard using the reference guidelines included in this issue of the Oklahoma Nurse or posted on the ONA website. Please refer to the Policies and Procedures posted on the website for guidance.

Reference Guidelines for ONA House Of Delegates

TITLE: Phrase that describes succinctly the recommended action
SUBMITTED BY: Include the name of one of the following (name a specific contact person)
ONA Board of Directors
ONA Structural Unit
Region Nurses Association
Individual ONA Member
RECOMMENDED ACTION(S): Similar to resolves in resolutions. Clearly identifies position or specific action requested. (The actions proposed should be of significant concern to nurses and the association and not a duplication of major initiatives of other associations or groups)
ONA MISSION: Identifies how the proposal relates to the mission of the Oklahoma Nurses Association. If the proposal does not relate to the mission, please explain why it should be considered.

BACKGROUND INFORMATION

RATIONALE:
A) Need: Why is action needed?
B) Historical Perspective: What has nursing or the professional association done or not done which: supports the action requested?

EXPECTED OUTCOMES:
A) Benefits: Who will benefit because of this proposal and in what way? (Community, association, profession)
B) Political Impact: How will this action be viewed by lay public, other nurses, nursing organizations, health care colleagues, legislators, etc.?

SUGGESTED ACTIVITIES: List specific activities that might be used to accomplish the recommended action. What should be done? Who will do it?

FINANCIAL IMPACT In collaboration with ONA staff and treasurer, estimate cost of suggested activities which implement recommended actions. Please call ONA (405-840-3476) for assistance. Suggested activities and financial impact information are intended to assist the delegates in understanding the impact of the proposal. The Board of Directors has the responsibility to select implementation strategies that meet the needs of the Association within budgetary limitations.

Mark your Calendar for the 2008 ONA Annual Convention

Standing on the Shoulders of Giants: 100 Years of Caring

October 29-31, 2008
Doubletree Hotel
Tulsa, Oklahoma

The Oklahoma Nurses Association Annual Convention is here again, so mark your calendars and make plans to attend. This year's centennial celebration is scheduled for October 29-31, 2008 at the Doubletree Hotel, Tulsa, Oklahoma. The theme for this year is *Standing on the Shoulders of Giants: 100 Years of Caring*.

As we prepare for an exciting convention, we offer you a host of activities including keynote speakers, concurrent sessions, exhibit hall breaks, and the ONA House of Delegates. Attendees should be sure to sign up for the our special events including the Award Luncheon, ONF and ONA-PAC events along with the Town Hall Breakfast.

Our keynote speaker, Dr. Lynn Wieck is a nationally-acclaimed speaker, writer and researcher on the topic of generational issues in the workplace. Dr Wieck's presentation ***It's a Great Time to Be a Nurse*** will focus on the positive side of the current nursing situation and how nurses can capitalize on being the most-trusted professional in the country. Dr Wieck will also speak on ***What Nurses Want: The Nurse Incentives Project*** which will address the retention of nurses in today's hospitals.

As in years past, the exhibit hall will have a variety of booths meeting the interests of all attendees. The ONA staff is currently gaining the support of several sponsors to make this the best convention yet. If you are interested in having an exhibit or being a sponsor, please contact the ONA office for more information.

The Convention registration form will be available in the next issue of The Oklahoma Nurse. Please also note that the convention brochure will be available in The Oklahoma Nurse; the ONA staff will not be mailing registration information to individuals. On-line registration will also be available this year at www.oklahomanurses.org

Don't miss out on an exciting ONA Annual Convention, October 29-31! Make plans to attend today.

Local News

Two Oklahoma Universities Receive $5 Million in Nursing Program Grants

Programs Established to Prepare Nursing School Educators

Nursing programs at Southern Nazarene University (SNU) and Oklahoma Baptist University (OBU) have each been awarded $2.5 million from an anonymous donor through Communities Foundation of Oklahoma to help combat the shortage of nursing instructors at Oklahoma's colleges and universities.

Based upon the success in meeting program goals each year, each grant will be awarded $500,000 per year for five years. Over 220 students will graduate from SNU and OBU with a master of science in nursing degree qualifying and requiring them to teach in Oklahoma nursing programs.

Beginning in September 2008, Southern Nazarene University will offer a nineteen month graduate program track leading to a master of science in nursing degree at both the Oklahoma City/Bethany and Tulsa locations. In addition to the traditional one night at week program, SNU will also introduce a weekend delivery system at the Oklahoma City/ Bethany campus. Students can attend class Friday night and all-day Saturday every third weekend of the month. These Oklahoma Incentive Nursing Graduate Scholars will receive $2,000 scholarships and $1,655 to be applied for individual laptop computers.

Oklahoma Baptist University's new Oklahoma City campus will offer an eighteen month program open to fifteen students per cohort, with ten total cohorts, leading to a master of science in nursing degree. Twelve students per cohort will receive full tuition scholarships. In addition, two students per cohort will receive graduate teaching assistantships to offset tuition costs.

The grants will also provide support for faculty support and development, instructional technology and supplies, and marketing costs for both universities.

Currently, an additional $3 million grant by the anonymous donor provides scholarships to students obtaining a Bachelor of Science in Nursing at the University of Oklahoma, Oklahoma City University, and Oklahoma Baptist University.

Communities Foundation of Oklahoma is a statewide foundation serving the charitable needs of all Oklahomans. For more information on this granting initiative or other services of the Foundation, please contact the management team at 405/488-1450 or toll free at 877/689-7726 or visit the CFO website at www.cfok.org.

Local News

Susan K.B. Jones Selected Clinical Nurse Specialist of the Year

Susan K.B. Jones

Harrisburg PA—The National Association of Clinical Nurse Specialists (NACNS) recently selected Susan K.B. Jones, to receive the 2007 Clinical Nurse Specialist of the Year Award. Jones, who resides in Oklahoma City, OK, is a Pediatric Clinical Nurse Specialist/Clinical Researcher at INTEGRIS Baptist Medical Center. Jones was officially recognized at the NACNS annual awards luncheon on Friday, March 8, 2008, during the NACNS annual conference in Atlanta, GA.

NACNS, an organization representing all clinical nurse specialists in the United States, created the award to nationally recognize a NACNS member for outstanding professional achievement in the three spheres of influence of clinical nurse specialist practice: providing expert patient or client care; setting quality and safety standards for nursing practice; and promoting system-wide improvement in care. Jones was nominated by Community Health Network leadership, physicians and peers.

"Susan is most deserving of this recognition from her peers," said NACNS President Sue Sendelbach. "Her practice exemplifies the unique and critically important contribution of the clinical nurse specialist to safe, quality, cost-effective care."

In her nomination, peers and colleagues noted that she provides leadership, vision, consultation, project management, facilitation and education for evidence based practice and quality initiatives. She engages bedside clinicians in evidence based practice (EBP) projects and nursing research that positively impact quality, patient satisfaction, and employee satisfaction. As a result of her influence, evidence based practice is now a part of the clinical culture and daily practice at Integris Baptist Medical Center.

Ms. Jones is also the Deputy Director for the Joanna Briggs Institute of Oklahoma, whose purpose is to improve health outcomes of Oklahomans through original research and translation of research to practice and education.

A leader among nursing organizations, the National Association of Clinical Nurse Specialists represents over 69,000 clinical nurse specialists across the United States. NACNS, founded in 1995, exists to enhance and promote the unique, high value contribution of the clinical nurse specialist to the health and well-being of individuals, families, groups, and communities, and to promote and advance the practice of nursing.

Center for American Nurses

The Center for American Nurses Calls For an End to Lateral Violence and Bullying in Nursing Work Environments

New position statement offers information and recommended strategies

Silver Spring, MD.—February 27, 2008—Research has consistently shown an unacceptable level of violence in the workplaces of registered nurses (RNs). The sources of this violence include patients and their significant others, physicians, other healthcare personnel, and—perhaps most disconcerting—other RNs. Lateral violence and bullying specifically have been extensively reported and documented among healthcare professionals, with serious negative outcomes for registered nurses, their patients, and healthcare employers.

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

Background

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

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

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

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

Solutions

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

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

Additional Information

A copy of the position statement is attached. It can also be accessed online at www.centerforamericannurses.org/positions/lateral violence.pdf

For interviews with Carrie Houser James or Dennis Sherrod, please contact Terri Gaffney at 703-655-2872 or by email at Center@GannettHG.com.

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

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

The Center for American Nurses is a national professional nursing organization that educates, equips, and empowers nurses to advocate for themselves, their profession, and their patients. The Center offers evidence-based solutions and powerful tools to navigate workplace challenges, optimize patient outcomes, and maximize career benefits. Established in 2003, the Center partners with its 42 organizational members, comprised of over 47,000 registered nurses nationwide, to develop resources, strategies, and tools to help nurses manage evolving workforce issues and succeed in their careers. Additional information about the Center can be found at www.centerforamericannurses.org

Continuing Education

Mass Casualty Triage

By Loren Stein, MSN, RN-BC
Education Coordinator of the Oklahoma Medical Reserve Corps
Project Director of the Oklahoma Nurses Association

As an approved provider, it is the policy of the Oklahoma Nurses Association to ensure balance, independence, objectivity and scientific rigor in all continuing nursing education activities. This educational program was developed free from control from a commercial interest, has no product endorsement or off-label product use.

Purpose: To familiarize Registered Nurses, Licensed Practical Nurses and nursing students with concepts related to mass casualty triage and to present an objective method to quickly identify those who require immediate attention, including the START or Simple Triage and Rapid Treatment system and JumpSTART the pediatric parallel to START.

Objectives

Identify characteristics of a mass casualty incident that impact the delivery of health care.

Identify a resource for the education of nurses in mass casualty response.

Compare different triage tools: START and JumpSTART

Apply the algorithm of START to case study casualties.

Apply the algorithm of JumpSTART to case study casualties.

Introduction to Mass Casualty

A mass casualty incident is usually defined as an event which exceeds the response abilities of the health care system. This definition takes into consideration the existing resources of a health care system. For instance, a metropolitan trauma center may be able to respond to a large disaster without overwhelming the system and yet if the same event were to occur in a rural community with few medical resources it would be deemed a mass casualty event. The philosophy of care also changes in a mass casualty incident. Under usual circumstances Emergency Departments work with a "do the best for each patient" philosophy. In a mass casualty event where the need exceeds the resources, the philosophy shifts to "do the best for the greatest number" (AMA, 2004).

Mass casualty incidents may occur for a variety of reasons. Natural disasters may result in both a single place and point in time type of disaster or they may result in a dynamic sequence of events. A storm producing tornados may touch down in a variety of locations causing a series of mass casualty incidents. Hurricane Katrina and Hurricane Rita were also examples of dynamic and catastrophic events with multiple communities experiencing a mass casualty incident. Despite the devastation of recent hurricanes, mass casualty incidents resulting from natural disasters are relatively rare and we are able to provide most Americans with early warning of natural disasters to allow them to either take shelter or evacuate.

Terrorism has increased the number of mass casualty incidents globally. Terrorist may use a number of methods to create a mass casualty incident, including chemical, biological, radiologic, nuclear and explosive methods. The most frequently employed method has been using explosives, such as the Oklahoma City Murrah building bombing, the London subway bombings, and the use of commercial jets on September 11th in New York City. Some countries, such as Israel, are more familiar with mass casualty incidents, have more experience responding to these events and have more published reports of evidenced-based practices.

Resources for Nurses in Mass Casualty Response

Nurses are a valuable asset in the potential response to a mass casualty incident. There are approximately 2.7 million nurses in the United States and in Oklahoma there are 48,000 RNs and LPNs. Specific knowledge is needed to enhance nurses' ability to assist with a mass casualty response.

One of the skills nurses need is an awareness of triage tools. In fact, the Nursing Emergency Preparedness Education Coalition (NEPEC) has identified as a core competency for nurses: "Describe accepted triage principles specific to mass casualty incidents, e.g. the START or Simple Triage and Rapid Treatment system." NEPEC is a resource for nurses which was founded in 2001 in response to the recognized need within the nursing community for nurses to be better prepared in the event of a mass casualty incident. Today the NEPEC has over 80 affiliates and continues to be a leader in the development of competencies and curriculum related to emergency preparedness.

The NEPEC website identifies the following: *"The NEPEC is currently focused in several areas: 1) increasing awareness of all nurses about mass casualty events; 2) leadership to the nursing profession for the development of knowledge and expertise related to mass casualty education; 3) dissemination of competencies for nurses at academic and continuing education levels; 4) establishment of a clearinghouse of information and web links for professional development of nurses; and 5) input into policy development related to nursing practice, education and research at the governmental and institutional levels."*

In addition to the ability to apply the most commonly used triage tool, Simple Triage and Rapid Treatment (START), nurses need to recognize the ways in which an incident can potentially impact the existing health delivery system and, in turn, impact the triage and treatment of disaster victims. Our current triage practices, including the START triage tool, assume that communication and transportation to a health care facility are functioning. Disasters may occur that damage our ability to rapidly transport victims to a receiving facility. Nurses may then need to adapt by providing triage, secondary assessment and treatment.

Triage

Triage comes from the French verb trier, "to sort". The goal is to sort the victims by injury to determine which victims need immediate attention to survive, which victims can delay their treatment by a few hours and which victims have minor injuries. Many different triage systems exist and are used around the world, for example, Triage Sieve and Sort is used in the United Kingdom and Careflight is the algorithm used in Australia (Wallis, 2002). Basic Disaster Life Support published by the American Medical Association uses MASS which stands for Move, Assess, Sort and Send (AMA, 2004). However, within the United States the most commonly used algorithm is START. The START system was designed in 1983 in California and was updated in 1994 (Hoag Memorial Hospital, 1994).

START

The START system does not have to be performed by highly skilled health care providers. In fact, it can be performed by providers with a first aid level of training. The goal is to quickly identify those individuals who require skilled care; the time needed to triage each victim is less than 60 seconds. START divides the victims into 4 groups and assigns each group a color. Those performing triage have tags in the four colors to identify the victim's status. The first step is to ask all the victims who need attention to move to a treatment area. This identifies all the victims with **minor** injuries who are capable of responding to commands and walking a short distance to the treatment area. This is the GREEN group and while they are now identified for delayed treatment, they do require some attention. If the members of this group do not perceive that they are receiving treatment they will self deploy to the hospital of their choice.

Next move systematically, not skipping any individuals, and assess respirations. If the respirations are greater than 30 tag the victim as RED (immediate), if there are no respirations reposition the airway. If there are no respirations after repositioning to open the airway, tag the victim BLACK (dead). If the respiratory rate is less than 30 bpm, check the radial pulse and capillary refill. If there is not a palpable radial pulse or if the capillary refill is greater than 2 seconds, tag the victim RED (immediate). If there is obvious bleeding, then control bleeding with pressure. Find another person, even a GREEN victim to apply pressure and continue to triage and tag individuals. If there is a radial pulse assess the victim's mental status by asking them to follow a simple command such as squeezing your hand. If they can not follow simple commands, then tag them RED (immediate) and if they can follow simple commands, then tag them YELLOW (delayed).

The algorithm below makes this easier to follow. Thus by checking three parameters, respirations, perfusion and mental status a group can be quickly triaged or sorted into 4 color groups based on whether they require immediate intervention which is the RED group, delayed intervention (up to one hour) which is the YELLOW group, minor injuries whereby intervention can be delayed up to three hours which is the GREEN group and those who are dead which is the BLACK group. The goal is to identify and remove those who require the most urgent attention. Those in the YELLOW and GREEN group will need to be reassessed to determine if their status is changing.

To apply the algorithm, let's use the following example: a 22 year old female who is visibly pregnant has an open fracture of her left lower leg, many bloody abrasions on her face and arms, respirations <30, radial pulse present, she is crying out for help and able to follow simple commands. 1) When asked to move to the treatment area she was unable to walk, therefore she is not in the green group. 2) Assess respirations. Her respirations are less than 30. 3) Assess perfusion. She has a palpable radial pulse. 4) Assess mental status. She is able to follow simple commands. Therefore, this woman is in the YELLOW group or Delayed group.

JumpSTART

Children have different ranges of normal respiratory rates depending on their age; therefore the START method based on a respiratory rate of 30 would not be appropriate for young children. Additionally, children are more likely to have a primary respiratory problem as opposed to a cardiovascular problem and children who are not

Continued on page 19

Continuing Education

Mass Casualty Triage

(Continued from page 18)

breathing may only require artificial respirations to be resuscitated. Additionally, children may not be easily divided according to who can walk to a designated location because of their developmental skills, their willingness to leave an injured parent and the parent's inclination to carry the child. An infant will not be able to follow commands regardless of physical condition and a toddler will not consistently follow commands. The modified START for children is entitled JumpSTART.

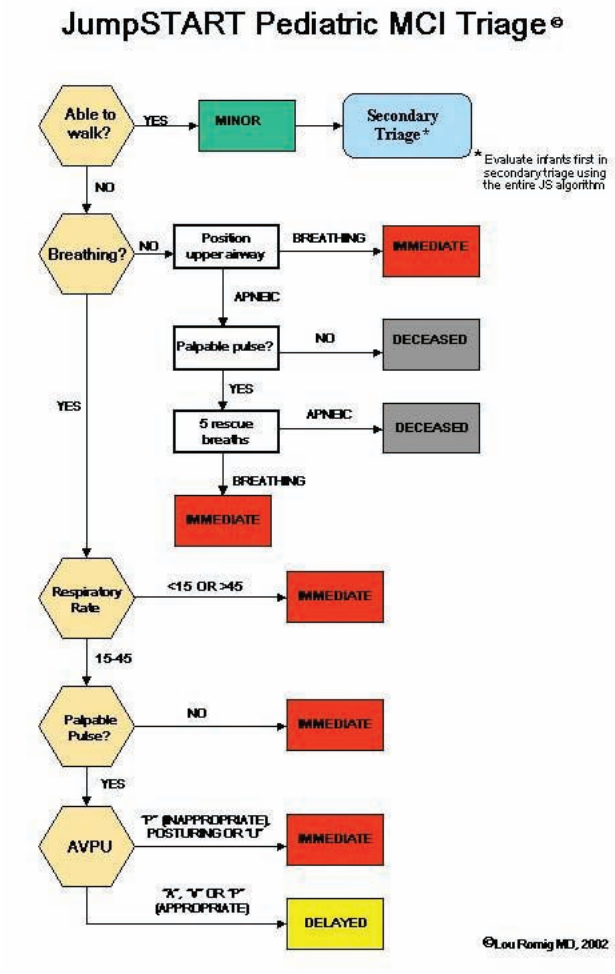
JumpSTART was developed in 1995 by Dr. Lou Romig to triage children in a mass casualty setting. It is used extensively in the United States and Canada and is intended to parallel the START system. Children present both the physiologic problems identified above and an emotional challenge to the responders. An objective tool assists responders to triage appropriately without diverting resources from others needing immediate attention. The tool was intended to be used for children between the ages of 1 and 8 years of age. It may not be easy to determine a child's age so the tool suggests that if the child looks like a child use Jump START and if they look like a young adult to use START. Modifications and additional assessment will be needed for children less than 1 year of age, with developmental delay, chronic disabilities or injuries incurred prior to the event. (JumpSTART, 2008)

The JumpSTART algorithm begins similarly to the START algorithm by asking all those who need attention to move to a specific location thereby determining those that can follow the instruction to walk. Upon assessing an individual child, if the child is apneic reposition the airway, then if respirations do not resume spontaneously, give 5 mouth to barrier rescue breaths. This is different from START. However, if 5 rescue breaths do not initiate spontaneous respirations, then the child is considered deceased. If the child is breathing, assess the respiratory rate. Respirations that are irregular, less that 15 or greater that 45 are criteria to tag the child as RED (immediate). If respirations are between 15-45 then assess a pulse. If the pulse is not palpable tag the child RED (immediate). If the pulse is palpable assess the mental status using the AVPU scale. If the child is Alert, responsive to Verbal stimulation or appropriately responsive to Pain, then tag the child as YELLOW (delayed). If the child is inappropriately responsive to pain or Unresponsive, then tag the child as RED (immediate). The AVPU scale is a rapid neurologic assessment scale commonly used by paramedics.

To apply the algorithm, let's use the following example: a toddler has blood on his face and arms but no visible bleeding, he is crying, after calming him momentarily his respiratory rate is 40, he has a palpable brachial pulse and he resumes crying loudly while you assess perfusion. 1) He is unable to follow the instructions to walk, but that would not be expected for a toddler. 2) Assess respirations. His respiratory rate is less than 45. 3) Assess perfusion. He has a palpable brachial pulse. 4) Assess mental status using the AVPU parameters. He is alert, soothes with verbal stimuli and is responsive to pain. Therefore tag the child in the YELLOW group (delayed).

Conclusion

Nurses enhance their ability to assist in the initial response of a mass casualty incident by learning to apply the START and JumpSTART algorithm to victims. Lives can be saved by quickly sorting victims so that resources are rapidly provided to those who most need it. To prevent an emotional response, an objective tool developed for each population is extremely valuable when determining the severity of injury to adults and children.



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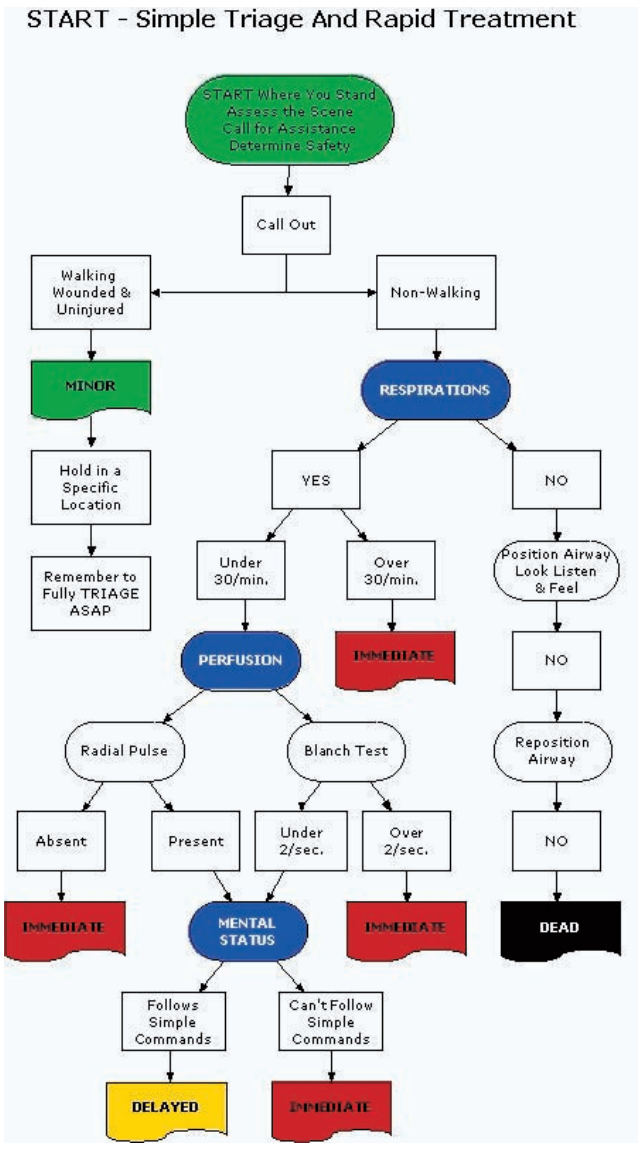

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Post-test and Evaluation Continued on page 20 and 21

Continuing Education

How to Earn FREE Continuing Education Credit

—This course is 1 contact hour—

1. Read the Continuing Education Article
2. Take the test on the next page. Complete the entire answer form. (Answer forms may be photocopied.)
3. Send
4. Mail or fax the completed answer form to:
   Mail: Oklahoma Nurses Association
   6414 N. Santa Fe Ave., Suite A
   Oklahoma City, OK 73116
   Fax: 405-840-3013

SCORES

To earn 1 contact hour of continuing education, you must achieve a score of 80% (8 of 10 correct.) If you do not pass the test, you may take it again. Certificates indicating successful completion of this offering will bear the date your answer form is received at ONA. Continuing education credit offered through May 30, 2009.

ACCREDITED

Oklahoma Nurses Association, Provider #05-2671-B, is an approved provider of continuing nursing education by the Texas Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. This activity meets Type 1 criteria for mandatory continuing education requirements toward relicensure as established by the Board of Nurse Examiners for the State of Texas.

QUESTIONS

- Phone: (405) 840-3476
- E-Mail: ona@oklahomanurses.org

Post-test for Mass Casualty Triage

Answer Form

Please complete this form and return to ONA, 6414 North Santa Fe, Suite A, Oklahoma City, OK 73116.

Name _____

Address _____

City _____

State _____ Zip _____

Professional Credentials: (Please circle) RN LPN student

State of Licensure _____

License Number _____

Employer _____

Employer Address (including zip code) _____

Please mark an "x" in the appropriate box to respond to test questions.

	A	B	C	D
1.				
2.				
3.				
4.				
5.				

	A	B	C	D
6.				
7.				
8.				
9.				
10.				

Purpose: To familiarize Registered Nurses, Licensed Practical Nurses and nursing students with concepts related to mass casualty triage and to present an objective method to quickly identify those who require immediate attention, including START, the Simple Triage and Rapid Treatment and JumpSTART, the pediatric parallel to START.

Evaluation

	Yes	No			
Are you a Registered Nurse?					
Objectives: How well did the program meet the following objectives? 1=not at all 5=completely	**1**	**2**	**3**	**4**	**5**
Identify characteristics of a mass casualty incident that impacts the delivery of health care.					
Identify a resource for the education of nurses in mass casualty response					
Compare different triage tools: START and JumpSTART.					
Apply the algorithm of START to case study casualties.					
Apply the algorithm of JumpSTART to case study casualties.					
Something I learned today will enhanced my ability to participate in the triage of injured following a mass casualty incident.					
Were the **objectives** relevant to the overall purpose?					
Was this teaching /learning method effective?					

	Yes	No
Did you perceive any inappropriate **bias**?		
Were you **informed of the disclosures** at the beginning of the presentation?		
	Hour	Minutes
How long did it take you to complete this entire activity?		

Continuing Education

Triage for Mass Casualty Post-test

1. Which of the following is the best definition of a mass casualty incident?
   a. A man-made event with many casualties
   b. A natural disaster which creates human suffering
   c. An event which exceed the health care system's response abilities
   d. A school bus collision in a rural area

2. Which of the following identifies the possible methods to produce a mass casualty incident?
   a. Biological & Chemical
   b. Radiologic & Nuclear
   c. Explosive
   d. All of the Above

3. Which organization is identified as a valuable resource for nurses regarding emergency preparedness education and information?
   a. Nursing Emergency Preparedness Education Coalition (NEPEC)
   b. Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
   c. Oklahoma Nurses Association (ONA)
   d. Center for American Nursing (CAN)

4. START stands for:
   a. Simple Treatment and Rapid Triage
   b. Simple Triage and Rapid Treatment
   c. Standard Triage and Rescue Treatment
   d. Standard Treatment for Rescue Triage

5. When using START, patients who are able to walk when directed are tagged as:
   a. GREEN (minor)
   b. RED (immediate)
   c. YELLOW (delayed)
   d. BLACK (delayed)

6. One of the very few treatments identified in the START includes:
   a. Begin chest compressions
   b. Reposition to open the airway
   c. Obtain a blood pressure
   d. Place a cervical collar

7. Using the START tool, a 15 year old male with a large head wound, including brain matter showing, with no respirations, no pulse and unconscious is tagged as:
   a. GREEN (minor)
   b. RED (immediate)
   c. YELLOW (delayed)
   d. BLACK (dead)

8. Using the START tool, a middle aged woman with an impaled foot, small piece of shrapnel in the right eye, respirations <30/minute, present radial pulse, awake and alert is tagged as:
   a. GREEN (minor)
   b, RED (immediate)
   c. YELLOW (delayed)
   d. BLACK (dead)

9. Using the JumpSTART tool, a 6 year old has a respiratory rate of 12, faint pulses, alert, and is responsive to verbal stimuli is tagged as:
   a. GREEN (minor)
   b. RED (immediate)
   c. YELLOW (delayed)
   d. BLACK (dead)

10. Using the JumpSTART tool, a toddler has a respiratory rate of 16, palpable brachial pulses and is unresponsive to verbal or painful stimuli is tagged as:
    a. GREEN (minor)
    b. RED (immediate)
    c. YELLOW (delayed)
    d. BLACK (dead)

OONE News

Horizontal Hostility: Another Look

Callie Craig*, MS, RN, CNOR, Surgery Clinical Nurse Manager, INTEGRIS Baptist Medical Center and Betty Kupperschmidt, EdD, RN, CNAA, Associate Professor of Nursing, OUCN

Introduction

Reports of bullying in public schools are all too common on the nightly news. Many adults express shock at this childhood cruelty. Unfortunately, bullying behavior is not exclusive to playgrounds and classrooms. This article represents a collaborative effort between the authors, the main goal of which is to discuss horizontal hostility among nursing professionals and to suggest potential strategies to avoid? this condition. The authors acknowledge this topic was addressed at the 2007 ONA Convention; however, many *Oklahoma Nurse* readers may have been unable to attend the convention and, thus, may not have this important information. Plus, the first author has some decidedly different information than the ONA Convention speaker, Kathleen Barthlomew.

Bullying and Horizontal Violence at Work

Many adults experience the same humiliating and harmful behavior at work. One study found that 30-50 % of US workers reported experiencing one act of bullying at least weekly in any 6-12 month period, and nearly 30 % experience at least two types of bullying frequently (Lutgen-Sandvik, et al. 2007). Workplace "bullying" is commonly referred to as horizontal violence, 'mobbing,' workplace aggression, & lateral violence. It is defined as negative actions towards one or more individual(s) which involve a perceived power imbalance and create a hostile work environment (Lutgen-Sandvik, et al. 2007). In this article, the authors differentiate between the two terms when and as necessary; however, they acknowledge that regardless of what we name the behavior, the behaviors are inconsistent with behaviors expected of professional nurses.

Table 1. Characteristics of Bullying (Lutgen-Sandvik, et al., 2007)

1. Intensity—describes the number of specific acts of aggression towards a particular person.
2. Repeated—a repeated pattern of behavior that occurs daily or at least weekly.
3. Duration—behavior must also occur over a sustained period of time, usually defined as six-months or more.
4. Power disparity—exists between the perpetrator and the target, to the extent that the target feels that they are unable to stop the bullying

Table 2. Behaviors Characterized as Horizontal Hostility and Bullying

Raising eyebrows	Making snide remarks
Responding to questions abruptly	Withholding information
Sabotaging	Establishing cliques
Scapegoating	Verbal abuse
Blaming one person consistently	Complaining about someone to others
Intimidating and humiliating	Excessive criticism
Making negative innuendos	Excluding co-workers
Violating personal privacy	Breaking confidences.

Lutgen-Sandvi, et al. describe 4 distinct features of workplace bullying as intensity, repetition, duration, and power disparity (See Table 1). McKenna and colleagues (2003) point out that although bullying takes many forms in the workplace, it most commonly takes the form of psychological harassment, which creates hostility, as opposed to physical aggression. The behaviors these authors and Longo and Sherman (2007) identified as horizontal violence or bullying are summarized in Table 2.

Bullying and Horizontal Violence at Nurses' Workplaces

Although horizontal violence is reported in many professional fields, researchers report high instances in the healthcare arena, specifically among nurses. This high incidence is often attributed to the fact that nursing is historically a female profession and, thus, evidences characteristics of an oppressed group. These characteristics comprise low self-esteem, self-hatred, passive-aggressive behaviors, and infighting among group members. The oppressed group typically develops aggression and anger toward the oppressor but does not express these emotions for fear of retaliation. Rather, they displace this aggression and self-destructive behavior within the oppressed group with subsequent infighting and self-criticism. Horizontal violence, thus, is the outcome by default (Dunn, 2003).

Several researchers have addressed horizontal violence among nurses. A landmark study conducted by Farrell (1999) examined nurses' views of aggression in the clinical setting. Of the 270 respondents, 30 % reported experiencing aggression on a daily or near daily basis. Of those incidents, 25 % were nurse to nurse aggression. This aggression included rudeness; abusive language; humiliation in front of others; failing to speak up for each other; denied access to opportunities; and refusing to help each other.

McKenna et al. (2003) examined the experiences of newly graduated RNs in their first year of practice. Of the 551 participants, 35% reported experiencing rude, abusive, or humiliating comments or receiving unjust criticism. Over 50% reported being undervalued by other nurses and 1/3 reported having learning opportunities blocked, feeling neglected, being distressed by interpersonal conflicts, and

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Horizontal Hostility

(Continued from page 22)

feeling unsupported by colleagues. More recently, Ulrich and colleagues surveyed 1783 nurses. They reported that 16% of the RNs personally experienced sexual harassment or a hostile work environment in the past year, with the highest incidence (22%) being reported by nurses from the mid west (Ulrich et al., 2005). These findings are consistent with Lutgen-Sandvik et al. (2007) who found that 28% of the RNs in their study met the operational definition of being bullied, yet only 9.4% of these same nurses self-reported themselves as bullied.

Outcomes of Horizontal Violence and Bullying

The outcomes of horizontal violence vary among individuals and groups. Members of oppressed groups feel alienated and feel they lack autonomy or control over their working conditions which intensifies the feelings of low self-esteem and powerlessness. Left unchecked, victims of horizontal violence may experience problems sleeping, disconnection from other staff, and exhibit depression and low morale, and use excessive sick leave (Longo & Sherman, 2007). Extreme cases of horizontal violence over sustained time can lead to permanent psychological damage, increased risk of heart disease, post-traumatic stress disorder, and even suicide (Lutgen-Sandvik et al., 2007).

When managers and professional staff RNs allow horizontal violence to continue, these behaviors can become the behavioral norm for and the culture of the unit: 'This is the way we do things around here'. New staff are socialized into this culture and behaviors and the destructive, toxic cycle continues, making it extremely difficult (if not impossible) to recruit staff that do not nor will not tolerate this behavior.

Horizontal violence has numerous ramifications for an organization. In the United States, the annual turnover rate for professional staff RN is 33% to 37% and ranges from 55% to 61% for newly graduated staff RNs. Indeed, as high as 60% of newly graduated RNs leave their first position within the first 6 months because of some form of lateral violence! (Griffin, 2004). This high turnover rate has major financial implications. Patient care is also compromised because of the decrease in communication and collaboration among staff members.

Employees who work in hostile work environments report reduced levels of job satisfaction, productivity, and concentration. They disengage from their work and their colleagues and, although they may be physically present, they are not emotionally and intellectually engaged in unit initiatives. This is known as "presenteeism" and it can have devastating effects on the overall morale of the unit. These employees report high levels of burnout and decreased mental and physical health. Absenteeism increases as victims become increasingly unable to emotionally or physically face this negative work environment (Sutton, 2007). Increased absenteeism is very costly for organizations as they pay 'top dollar' for agency personnel. Increased agency RN usage poses unique challenges for Managers and staff as they attempt to build cohesive work groups when the group members change weekly or even daily.

These negative consequences are not unique to healthcare. Sutton (2007) notes that companies that tolerate horizontal violence not only have more difficulty recruiting and retaining the best and the brightest talent but they are also prone to higher client churn, damaged reputations, and diminished investor confidence. Innovation and creativity may suffer, and cooperation may be impaired. Communication among employees becomes blocked and can lead to break downs in work processes and standards. If knowledge of abusive behavior becomes public, investors may be unwilling to support the organization, leading to financial ramifications that extend well beyond the unit level.

Strategies to Address Horizontal Violence and Bullying

Given the destructive nature of horizontal violence in the workplace, it is important to seek methods to combat this problem. Many victims of workplace bullying have sought justice through lawsuits against the aggressor and/or company. Scott (2007) reports that some victims have received settlements of up to $1,000,000 further proving the point that workplace bullying is not only a human relations issue but a financial one. Some states are considering taking political action against workplace abuse in the form of "anti-bullying" legislation. In 2007, the State of Oklahoma passed anti-bullying legislation, House Bill 1467, the Abusive Work Environment Act.

Unfortunately, laws and policies can only go so far to prevent aggressive, unprofessional, and unkind behavior in the workplace. Given that the very nature of horizontal violence can be covert and subtle, the question must be asked: How do we change the behavior of employees when no one is watching? Several strategies to promote healthy work environments have been suggested. Longo & Sherman (2007) propose a seven step model for decreasing workplace violence. This model has been modified to fit within nursing as a profession and is presented as Table 3.

Table 3. Model for Decreasing Workplace Violence (Longo & Sherman, 2007)

Step 1. Analyze the culture of the unit to identify/validate the presence of behaviors characteristics of horizontal violence

Step 2. Name/acknowledge the problem as horizontal violence

Step 3. Educate all levels of staff, beginning with the professional RNs, about horizontal violence and negative effects and outcomes

Step 4. Allow victims to share their experiences by making the environment safe for sharing

Step 5. Create and enforce a zero tolerance process for addressing all form of non-professional behavior (horizontal violence and bullying)

Step 6. Foster professional self-evaluation (staff RNs and Managers), being totally cognizant of the expectations of a profession as explicated in the ANA Code of Ethics

Step 7. Arm staff RNs with and expect use of tools for addressing conflict within the context of carefronting as strategy (as developed by Kupperschmidt, 2008).

Griffin (2004) examined the effects of using cognitive rehearsal, techniques based on cognitive learning theory, as a means to shield participants against horizontal violence. Twenty-six new graduate RNs received information about horizontal violence in nursing practice and were taught to use cognitive rehearsal techniques. The process involves several steps. First, participants receive conceptual and practical information about horizontal violence in the workplace. Receipt of this information allows participants to process and contemplate the information they have received before they encounter and need to react to incidents of horizontal hostility. The theory is that, armed with this knowledge, RNs can respond appropriately and professionally rather than allowing emotions and anger to take control. Although results of the study were inconclusive, the author noted participants reported feeling better prepared to respond appropriately to such behavior if and when they encountered it in the workplace.

Manion & Bartholomew (2004) propose building community in the workplace as a strategy to retain nurses in the profession and promote healthy work environments. They use Peck's famous definition to define community as a group of individuals who communicate honestly with each other; whose relationships go deeper than their masks of composure; and who have developed some significant commitment to share life's deeper experiences. For true community to exist, group members must be committed to each other; be willing to allow and encourage opposing points of view; be contemplative and willing to continually examine themselves; and be willing to share vulnerabilities. Kupperschmidt (2007) recommends carefronting and provides a model to assist in developing the skills of carefronting. Further, she stresses that according to the *ANA Code of Ethics*, Provision 6, each professional staff nurse must be willing to share accountability with the Nurse Manager for developing a healthy work environment (Kupperschmidt, 2004). The very definition and central components of a professional work environment do not allow for tolerance of horizontal violence and bullying behaviors!

Conclusion

In conclusion, whether an organization utilizes one method or many to combat horizontal violence, it is essential for all healthcare organizations to assess their work environments and confront bullying and aggressive behavior. Workplace bullying comes packaged with a multitude of emotional, physical, economical, and societal consequences. In a profession that is facing a current and predicted worsening shortage of professional staff nurses and Nurse Managers, professional nurses cannot afford to bully their next generation out of the profession! Taking a firm stand against workplace aggression and creating a community of professional RNs who are willing and able to confront all form of horizontal violence and bullying is essential not only for the survival of the profession but for the safety of the patients we serve.

• Callie is a May, 2008 graduate of the Administration Pathway, OUCN.

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IONE News

Career Diversity: How Do We Tell Our Story?

by Geraldine Ellison, PhD, RN
Interim Executive Director IONE

A recent editorial by Ellen Olshansky, (2007) editor of the *Journal of Professional Nursing* caught my eye! In it, she describes speaking with a group of nursing *education administrators* in which most said that they had not planned a career in academic nursing administration and had no idea at the beginning of their nursing career that they would end up in nursing education. These comments certainly mirror my own experience and that of most faculty I know. My guess is that this is a common experience regardless of which area of nursing we are in. We enter nursing with one idea in mind, that of caring for those who are ill, and in a hospital setting, and then, over the course of our careers, we change directions and perhaps many times. The nature and breadth of nursing let's us do that!

Interestingly, studies have demonstrated that a personal experience with nurses via a hospitalization either for one's self or a close relative prompted many nurses to choose nursing as a career. There are a number of studies that examine reasons for career choice, and there are certainly several reasons cited. In searching out reasons or characteristics that those of us who attempt to recruit others into nursing (and face it, that should be all of us!) could use or influence in some way, the following seem to offer some direction:

- A motive to help others (make a difference in others' lives is another way to express that motive),
- Feeling that what you do is important work (valued by others),
- Exposure to someone who is a nurse (and for teens, a media communication about nursing),
- Personal experience with hospitalization.

As we think about these characteristics, the first one indicates the *type of person* we should be looking for to recruit into nursing, those motivated to help others, those for whom "making a difference in the life of another" moves them to action. In most instances, the presence of this motive signals a relative level of emotional health and a respect for the social nature of human existence that makes a good nurse.

The second characteristic, feeling that what you do is valued, is important and is reflected in the way we talk about what we do and in how we treat each other. In my opinion, hospitalized patients are going to need a nurse to save their lives! Lives are saved everyday by good nurses, who prevent and rescue patients from untold adverse events! But at the end of the day, if roles are executed correctly, there isn't much to talk about! Perhaps it would help us speak more effectively about the value of nursing if we talked about the lives saved and the harm prevented by the actions or non-actions of nurses everyday.

The second and third elements, exposure to a nurse and a personal experience with hospitalization, reminds us, that just like we all learned in psych, we need to apply the "therapeutic use of self" to recruit others into nursing. Non-nurses thinking about a career choice need to see and hear a real nurse who speaks to how nursing care make a difference and sometimes *the* difference between health and disability, between life and death. They probably don't need to hear our complaints, no matter how legitimate they are! Children and youth are everywhere. You can find them in your neighborhoods, schools, churches and hanging out at the malls. They even visit their parents, grandparents, neighbors, and friends in hospitals. When you see them, think of it as an opportunity to plant a seed about nursing as a career option. Let them know that nursing is a career with such rich diversity that they can change careers those 7 time predicted for this generation and still remain in nursing.

There is an abundance of resources available to us in reaching and encouraging youth to consider nursing. For example, check out *The Power to Make a Difference Campaign* through the North Carolina Center for Nursing. The website is http://www.ga.unc.edu/NCCN/. When you reach this website click on recruitment and retention for the many interesting ideas that can help us think about how to approach children and youth about nursing.

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Can We Call On You?
Volunteer Nurses Needed by American Red Cross

Oklahoma City, OK—All RNs, CNAs and LPNs with diverse skills are greatly needed by the American Red Cross of Central Oklahoma to respond with Disaster Relief teams in times of disasters, both small and large. We depend on quality volunteers to call when disasters strike and nurses help with 70% of all our assistance.

In smaller disasters, American Red Cross nurses provide case management to individuals and families who lose medications and durable medical supplies. For example, Red Cross nurses talk with a child's doctor for asthma medication lost in a fire; advocate with durable medical equipment companies for supplies lost; or, build partnerships with agencies throughout the year in preparation for coming disasters. These are all efforts that occur day or night. The necessary training will be provided through the American Red Cross with both online and class room sessions depending on the area of interest and your of availability.

About 30% of the chapter's disaster response entails larger disasters. Larger disasters like tornadoes and ice storms may require the opening and operating of smaller shelters. In these disasters, a Red Cross nurse is trained to provide health services in a shelter with the support of other Red Cross volunteers. In a shelter, our primary function is to cover first aid, then, secondarily, case management.

With spring weather in full force we are recruiting licensed nurses to create a qualified and dependable volunteer pool to help the Red Cross in times of need. Reserve nurses may be required to assess individuals after home and apartment fires, in a shelter setting after a large disaster or other settings as they arise.

Special training will be available to those interested in becoming a volunteer. Please contact Annie Lucas at 405-228-9546 or email her at alucas@arcok.org.

MORE Hepatitis C Outbreaks in the News—Don't Let This Be You!

Becky Coffman, MPH, RN, CIC

Strict adherence to basic principles of aseptic technique is necessary to avoid transmission of hepatitis C (HCV), hepatitis B (HBV), and HIV when preparing and administering parenteral medications. Several outbreaks of HCV and HBV have been documented within ambulatory care facilities in the United States, including a recent report by the Associated Press on February 27, 2008 of a clinic in Nevada in which as many as 40,000 persons may have been exposed to HCV. A preliminary joint investigation has identified the re-use of syringes (not needles) and the use of single dose vials of anesthesia medication on multiple patients as the potential sources of contamination.

According to the Centers for Disease Control and Prevention (CDC), outbreaks related to unsafe injection practices indicate that some healthcare personnel are unaware of, do not understand, or do not adhere to basic principles of infection control and aseptic technique. A survey of US healthcare workers who provide medication through injection found that 1%-3% reused the same needle and/or syringe on multiple patients. Among the deficiencies identified in recent outbreaks were a lack of oversight of personnel and failure to follow-up on reported breaches in infection control practices in ambulatory settings[1].

In Oklahoma, an outbreak of viral hepatitis associated with a pain management clinic was investigated by the Oklahoma State Department of Health (OSDH) in 2002. The practice of sequentially administering sedation medications using the same syringe and needles to all patients in an individual clinic session through a heparin lock attached to an IV cannula was determined to be the mechanism for patient-to-patient transmission of HBV and HCV. This unsafe practice was employed because the registered nurse anesthetist believed the heparin lock provided a sterile field.

Other outbreaks of HCV have occurred in New York City and Nebraska and have involved private physician's offices and hematology/oncology clinics.[2] Outbreaks such as these are unnecessary and completely preventable. Because healthcare professionals may be unknowingly placing patients at risk of exposure to bloodborne pathogens, the OSDH is encouraging all clinicians to review their procedures and adhere to the following "Do's and Don'ts" of injection practices:

Please contact the OSDH, HIV/STD Service with questions or concerns at (405) 271-4636.

References:

1 Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 Http://www.cdc.gov/ncidod/dhgp/pdf/isolation2007.pdf

2 CDC. Transmission of Hepatitis B and C Viruses in Outpatient Settings—New York, Oklahoma, and Nebraska, 2000-2002. MMWR 2003; 52(38): 901-906.

3 Infection-Control and Safe Injection Practices to Prevent Patient-to Patient Transmission of Bloodborne Pathogen. CDC. (2003). Retrieved February 29, 2008, from http://www.cdc.gov/ncidod/diseases/hepatitis/spotlights/ambulatory.pdf

Do's and Don'ts of Safe Injection Practices

DO's

- Use a sterile, single-use, disposable needle and syringe for each injection and discard intact in an appropriate sharps container at the point of use.
- Use single-dose medication vials, pre-filled syringes, and ampules when possible.
- If multiple-dose vials are used, restrict them to a centralized medication area or for single patient use.
- Store vials in accordance with manufacturer's recommendations and discard if sterility is compromised.
- Use aseptic technique to avoid contamination of sterile injection equipment and medications.
- Report observed unsafe injection practices to management.

DON'Ts

- Do not administer medications from single-dose vials to multiple patients or combine leftover contents for later use.
- Never re-enter a vial with a needle or syringe used on one patient if that vial will be used to withdraw medication for another patient.
- Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.
- Do not re-use syringes or needles when entering an IV port or IV line, even when the port is distant from the patient.

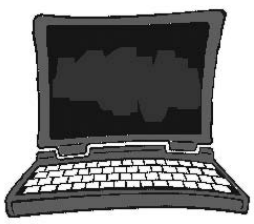
Adapted from: Infection-Control and Safe Injection Practices to Prevent Patient-to-Patient Transmission of Bloodborne Pathogens. CDC. (2003). Retrieved February 29, 2008, from http://www.cdc.gov/ncidod/diseases/hepatitis/spotlights/ambulatory.pdf

For additional information, see the CDC Injection Safety website at www.cdc.gov/ncidod/dhqp/injectionsafety.html

Discover the Advantages of Career Websites

Over 80 million people search career websites each week. Why should you be one of them?

To understand why so many job seekers are turning to the internet to help guide their job search and what drives employers to post their open positions online, one can look at the undeniable trend of the internet increasing productivity. Career websites have made traditional job search and recruitment methods like advertising in newspapers and visiting places of business seem outdated and inefficient.



The main underlying incentive for job seekers and employers to go online for job searches and recruitment is that it saves valuable time. Researching various opportunities, submitting resumes, writing cover letters and interviewing consumes a significant amount of time. Anyone who has ever initiated a full-fledged job search can attest to this. Managing a job search online cuts out many of the unnecessary processes found in non-electronic job search methods. In addition, employers can post opportunities instantaneously, speeding up the entire process and helping them fill positions faster.

Online career resources also provide easy access to both candidates and employers. Job seekers can easily retrieve a list of opportunities filtered by job category, location and even required qualifications. On the other side, employers can receive resumes and applications via email and screen candidates all with just the click of a mouse.

Furthermore, managing recruitment online presents the opportunity to display a more detailed job description. This helps employers paint a vivid picture of what the position will entail and also aids job seekers in determining whether or not a certain job is the right fit. In contrast, outdated career services like newspaper classifieds ads are significantly restricted in the amount of space they allow for a description which leaves many questions and concerns unanswered.

Overall, it is easy to see why more and more people are relying on the internet to explore new career opportunities or to find the perfect candidate. Simply put, old fashioned methods can not compare to the significant advantages that online job search and recruitment present. Discover the benefits yourself by visiting the ACRONYM Career Center, ASSOCIATION NAME's very own online career resource at http://wra.associationcareernetwork.com.

"Who is logging on to career websites?" BizReport. 11 Feb. 2008.

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A YEAR IN TANZANIA

Maggie D. Mendenhall, RN

The past year of my life was spent in a village in Tanzania, Africa. I am a 2006 graduate of OU Nursing school on the Lawton campus. My whole purpose for being in Sawala, Tanzania, was not just to say "Hey! I did this. I survived one whole year in the bush of Africa." In fact, if you knew me well enough, you would know that I do not do things simply for the ability to say "I did that!" I am not that adventurous or daring. I do believe, however, that if my God is leading me in a certain direction or laying it so heavily upon my heart to take a leap of faith, then I must do it. There is no other option. Before I left, a friend asked me, "Do you think you'll make it through the year?" For me, there was no option. So, what was my purpose? I should probably just quote my purpose from the biggest influence in my life, the Bible. "We loved you so much that we were delighted to share with you not only the gospel of God but our lives as well, because you had become so dear to us" (1 Thessalonians 2:8, New International Version).

I shared my life with the villagers of Sawala, Tanzania last year by providing them an education. In 2004, less than 15,000 students graduated high school in Tanzania. Presently, approximately 850,000 children finish primary school and the government only has enough room to educate 98,000 on the secondary education level. 752,000 will never have the chance to go to school without the addition of facilities and teachers. This is where Village Schools International (VSI, www.villageschools.org) comes into the picture. The organization I worked for in 2007 originated in 2005 and is committed to starting schools in rural areas of Tanzania. Its purpose is to give children finishing primary school an opportunity to further their education and help decrease the poverty that is so prevalent in their country. VSI currently has twelve schools in place throughout Tanzania, and its work began only three years ago. With almost 3,000 students now in its schools, VSI is doing amazing work. I was blessed to be able to see my students pass their national exams that are taken by every second year student in secondary schools in Tanzania. Our students at Sawala ranked 28th in English and 14th in Biology in 2007. The two schools old enough to have students this testing category, Madisi and Sawala, had a 100% pass rate for the national exams, which has never happened in a single government school in Tanzanian history!

Anna (left) and Yasinta (right)

In Sawala, I worked as a Bible Knowledge, English, and Biology teacher where the second VSI school was built by the students and their parents personally. My roommate, Tamara, and I also took turns after school teaching English to people in the village who wanted to learn the language. In addition to teaching, I became the school nurse unofficially simply because of my background. It did not take long for students and villagers alike to come to me with problems ranging from cuts and minor wounds to broken limbs and burns once they knew the American teacher had a degree in nursing. The fact that I was an RN going into this experience to be a teacher really struck a few people as odd here in America. I knew, however, going into this that my nursing skills would prepare me for a much wider spectrum of experience once the year was complete. I was right! I not only got to help others with the knowledge I had, but I also was a first-hand witness of how important good healthcare really is. While in Tanzania, I had my fair share of intestinal illnesses, including giardasis, dysentery, and worms. I also had malaria, which had me in bed for three days with a fever ranging from 102°-104°. The three weeks of pure weakness that followed was probably worse for me than the fever, because I was in bed that whole time. However, the scariest thing I think that could have happened was the day my parents arrived in the village at the end of my time in Sawala. I cut a branching artery in my left arm with an army knife. Now, talk about trusting God to take care of you when you're bleeding profusely and are stuck in the bush with no medical care closer than an hour away and inadequate at that! Because my parents had literally just arrived, we happened to have access to a vehicle to get us to a tea field factory hospital and I was stitched up in their clinic. While it was not the way I would have chosen to get stitches, I have never been so grateful for that tea factory clinic with the "diploma doctor."

The prevalence of poverty in Tanzania goes without saying, as with most African countries. The education system is one of the poorest in Africa, and that is why Village Schools International feels the need to intervene in this area. Education of a child has the same effects in Tanzania as in America. Poverty, disease, and mortality rates all decrease with the increase of knowledge in any society. While education was the main purpose for my being in Sawala, the AIDS pandemic was something we encountered every day in the village. One of our best friends, Owen, was a fourteen-year-old boy whose mother and father had both died of AIDS, his aunt who was caring for him had AIDS, and he had AIDS. This was an everyday reality in the village. Approximately 60% of the people in my village had HIV. Tamara and I did as much HIV/AIDS education as possible throughout the village and in our school. This was the first step. Understanding the transmission of and effects of this disease was something we strived to make known so that those we were educating would take the facts about this disease to everyone they knew. We spoke to the Lutheran church and took villagers to be tested at the tea factory clinic. We had about ninety of our students tested in the time that we were there, as well.

Many people want to know what life was like for me physically. Well, you can probably already guess that I was in some primitive conditions. The lack of electricity and indoor plumbing were the least of my worries, however. Here is a small excerpt from my journal entry in the first week of training in a village called Igoda in Tanzania: "My first night in the village was horrible. I know that's drastic, but I cannot get used to hearing rats run around and *feel* them run around on me! All will be well, I know... It is just very difficult right now. I do keep reminding myself that my God will get me through this. And Anna, Ester's friend, had some very encouraging words. She kept calling me a gift from God. She was so thankful for my being there, and she iterated over and over again how only God could have brought us together—me being from Oklahoma and her from Igoda, Tanzania. 'The Lord is good!' as Anna says."

Sawala Secondary School

Maggie with children and her friend, Mama Nasibu, at Kilima tea factory.

While the feel and sound of rats never really was something I became comfortable with, it does pale drastically in comparison to what I believe are the real difficulties of adjusting to life in a different culture. The physical things do not matter. It's the emotional adjustments of simply being thrown so far out of your comfort zone that you must find the strength in something or someone to get through the worst. For me, being a Christian, this was in my God. Two verses that I clung to the entire time I was in Tanzania are found in 2 Corinthians 12:9-10. The apostle Paul says this about what God spoke to him: "But he said to me, 'My grace is sufficient for you, for my power is made perfect in weakness.' Therefore, I will boast all the more gladly of my weaknesses, so that the power of Christ may rest upon me. For the sake of Christ, then, I am content with weaknesses, insults, hardships, persecutions, and calamities. For when I am weak, then I am strong." The intestinal diseases, malaria, artery-nicking—all the stuff that one might endure in Tanzania—truly does pale in comparison to the extreme life lessons learned within such an incredible community of people. I learned what loving others despite differences really means. I learned that my little bit of knowledge as a nurse and educated woman in America can go a long way in someone's life who may never have gotten the chance to go past the seventh grade without that help. Most importantly, I learned that the lack of "things" found in the culture that I lived in was the biggest blessing in my entire life. Was it easy? Never. But, it was the hardest, *best* thing I have ever done in my life, knowing that I was obedient to my God in using what He gave me to help those who are less fortunate simply because of geography. I would debate their fortune is much larger than anything I will ever know again, however, when it comes to understanding what loving others and serving others really means.

As I think about whatever I will do in the future, I know it can be used for God's glory. But probably nothing will ever come to close to comparing with my last year; 2007 is forever engrained in my head and on my heart as being the most life-changing, most incredible journey in my life. I learned while there that geography doesn't matter. I am not meant to be in Africa for my whole life, like some, but I did bring the principles I learned there home with me and am trying to live them out in my daily life. It is my prayer that whoever hears about the work done in Tanzania will find some way to support the efforts that the leaders of VSI have put their hearts and souls into for these children.

Anna asked me once in the first two weeks of my time in Tanzania if I missed home. Of course my answer was at that time, "Yes." I asked if she loved her home like I did mine. She was full of joy as evidenced by that bright, white smile. She said, "Oh yes! I love my home and my country. I love Africa very much. God is good - He has given this to me. I love Africa! I love God!" For me, that is my exact sentiment as I remember my time in that beautiful place in Tanzania. The people, the place, and my God have touched my heart in the past year more than I could have ever thought possible. Colossians 4:17 says, "See to it that you fulfill the ministry that you have received in the Lord." For 2007, I fulfilled the ministry I received as a gift from God.

Maggie Mendenhall is a 2006 Graduate of OU Nursing School.

Incorporating Joint Commission Standards into Nursing Education

by Helen Farrar, BSN, RN, BC

Staff nurses working in today's healthcare environment face a variety of pressures. Unstable patients in acute care settings have complex needs and present a challenging and demanding working environment. While providing quality patient care, nurses must protect patient safety and incorporate current research and best practices into their practice. The stakeholders, employers, patients, healthcare organizations and the nursing profession, measure a nurse's competency according to the nurse's ability to apply national practice standards in the clinical setting. The Joint Commission, a national organization for the accreditation of hospitals and other health care organizations, incorporate patient safety standards within their criteria for accreditation. As hospital employees, nurses are accountable to practice according to the standards which may further amplifying the pressure nurses may feel.

Most healthcare providers recognize that Joint Commission standards have increased the level of patient care quality throughout the United States. Many providers and organizations expend large amounts of time, energy and financial resources to prepare for Joint Commission evaluation. Part of this process includes the preparation of staff to respond to questions that Joint Commission site visitors may ask about organizational processes and outcomes.

The nursing staff is often the primary focus of this preparation because they perform the majority of institutional day-to-day functions and, thus have direct influence on patient care. Nurses have also been identified as leaders in directing care practices to promote patient safety. During 2005, the American Organization of Nurse Executives identified patient safety as a major initiative and identified nurse leaders as the primary caregiver that is expected to meet competencies related to patient safety. Nurses have accepted this responsibility and practice according to Joint Commission and professional nursing organization standards by delivering safe, evidenced based interventions and by utilizing hospital policies and procedures. However, when Joint Commission site visitors arrive, some nurses express fear that 1) they may be doing something wrong; 2) may not know how to respond to questions or 3) may be punished for actions that do not meet standards even after lengthy pre-visit preparations by the organization.

Discussion about this phenomenon led faculty at Rogers State University in Claremore, Oklahoma, to consider incorporation of Joint Commission standards into nursing courses for Associate in Applied Science students. Analysis of the curriculum revealed that students were typically exposed to information about the Joint Commission and the standards for patient safety on a random basis and usually during clinical rotations. Thompson, Navarra, & Antonson (2005), recommended that students receive real world practice around patient safety issues. They stressed that it was essential for faculty find more effective ways to acculturate students into the work environment so they don't arrive ill prepared to practice as part of an interdisciplinary team. Based on this analysis, faculty postulated that if nursing students were introduced to Joint Commission standards as an integral part of the curriculum they would demonstrate greater interest and participation as a graduate nurse. It was also believed that the opportune point to begin nurse preparation for participation in Joint Commission standards was during the time students were being socialized into the profession by building their professional identity and values.

Beginning fall 2007, a basic overview of Joint Commission and its associated standards was added to the theory courses of the Associate in Applied Science nursing program at Rogers State University. All students received a 15 minute presentation about Joint Commission and National Patient Safety Goals during orientation to the nursing program. Prior to the start of the semester, faculty identified points in the curriculum where Joint Commission 2007 National Patient Safety Goals would apply to theory and clinical instruction. Twelve standards were included in the first semester theory class. These standards were also included in the laboratory instruction for the first semester. The standards were included in lecture presentation, syllabus content and assigned reading material. These standards were also distributed to all clinical faculty members to incorporate into clinical instruction.

During the curriculum review process, RSU nursing faculty expressed concern that by adding this content, other content might be deleted. Giddens and Brady (2007) noted that it was a challenge for nurse educators to determine what aspects of traditional nursing practice to retain, what content to let go, and what new knowledge to incorporate. To prevent loss of essential content concurrent with successful incorporation of the new content, faculty utilized the theory of concept based curriculum. Concept based curriculum emphasizes concepts across environmental settings, the life span, and the health-illness continuum as cited by Giddens and Brady (2007).

The conceptual approach is designed to assist students to make connections among multiple pieces of information. For example, it is universally recognized that hand washing prevents the spread of microorganisms. Historically, nurse educators have used a content based curriculum to teach this information. In this model, faculty tended to teach specific skills and theory in a linear fashion. Hand washing would have been taught as a preventive measure during standard care content only. During the addition of Joint Commission and National Patient Safety Goals into course curriculum, RSU faculty utilized the model of concept based curriculum. Using this approach, the principle of hand washing is introduced in the laboratory setting as standard clinical practice. In the theory course related to infectious disease, theory content related to professional behaviors and as an underlying principle in all coursework pertaining to health promotion and maintenance. This layering of the concept allows for the student to "construct deep meaning and understanding" that promotes critical thinking rather than memorization of facts (Giddens & Brady 2007). When the faculty taught hand washing and its role in infection prevention, they included that this was also a Joint Commission National Patient Safety Goal to reduce the risk of health-care associated infections. This National Patient Safety goal was also emphasized as part of patient advocacy and the responsibility of the Registered Nurse during content related to professional behaviors.

The remaining National Patient Safety Goals identified by Joint Commission in 2007 were included into other courses within the curriculum in a similar fashion. These Goals were emphasized throughout the content with the exception of the Goal of implementation of these goals and associated requirements into the organization and identification of safety risks by the organization since Joint Commission does not oversee the educational setting.

Incorporation of National Patient Safety Goals into the curriculum continues for nursing courses taught during the spring 2008 semester. Faculty teaching content reported minimal difficulty including these Goals into their original content. Clinical faculty report that emphasizing Joint Commission standards results in the students demonstrating greater adherence to practice standards. They are more receptive to discussing the Joint Commission visits and requirements with clinical facility staff.

In conclusion, this curriculum change was made to increase the probability that student nurses and beginning practitioners would possess greater skill and confidence in practicing Joint Commission patient safety standards. Because these principles were introduced to them during the development of their nursing identity, the faculty believes these graduates will act as leaders to promote patient safety.

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Planning For Financial Success

by Matthew D. Jantzen

Think of your family as a business. It has financial goals and must produce ongoing revenue to meet those goals. And to reach those goals, like a business, you and your family need a financial strategy.

You'll need to begin, of course, by defining your goals. Most people, for example, want to save to buy a house, pay for college or prepare for retirement. Your financial goals should be more precise. Where do you want your home and how large should it be? What college do you want your child or children to attend and when will they be attending?

A financial professional can work with you to identify your goals as precisely as possible and help to estimate how much money you will need to achieve those goals. Once that first step is accomplished, you can determine how much money you will need to save and how much of a return you will need on your investments to meet your goals.

You cannot, of course, project with complete accuracy how much college will cost 10 years from now or even how much a house will cost in a few years, but estimating based on today's prices and adjusting for inflation will at least give you a rough idea of how much you need to save.

In addition to looking at how much you need to save, your financial professional will look at your investing time line—how long you have to save until you need money for each of your financial goals—and your tolerance for risk. Based primarily on these three factors—the amount of money you'll need, your timeline and your risk tolerance—your financial professional should be able to recommend a mix of investments designed to help you achieve your goals.

At this point, you should be able to determine quickly whether your goals are realistic. Many people have unrealistic goals. You may want a second home in the Hamptons and a Harvard education for your children, for example, but that doesn't mean you'll never be able to afford it, no matter how much of your income you save.

To achieve your financial goals, you will also need to manage risk, so your financial strategy should also consider your insurance needs. Will you need life insurance to protect your family and, if so, how much and what kind? What about disability protection or long-term care insurance? A financial strategy typically considers all of these issues. Depending on your goals and financial means, a financial strategy may also consider issues such as estate planning and charitable giving.

A financial strategy is a life-long roadmap for helping achieve your financial goals. Stick to the directions it provides and you should be on your way to achieving your goals.

The journey's a long one, though, and it's not unusual to go off course at some point or for your strategy to change along the way. As such, it is important to review your plan with your financial professional at least yearly.

When you meet with a financial professional, you can work together to gauge how your investments are performing in relation to your financial goals. If performance isn't up to expectations, you can always make adjustments. If it is exceeding expectations, you'll have some leeway for those times when it doesn't.

Life Cycle Planning

It is important to keep in mind, of course, that financial goals change.

Financial professionals typically recommend reviewing and adjusting your financial goals and investment strategy at different stages of your life. This approach, called "life-cycle planning," breaks a person's life cycle into early career, wealth accumulation, pre-retirement and retirement.

Each stage has different needs. Saving can be difficult during the early career, when income is low and financial demands are high. Marriage, children, initial home ownership and paying off student loans are typically the major financial responsibilities during this stage.

During the mid-career, or wealth accumulation, stage, parents are typically saving for their children's college educations, achieving financial independence, and investing for retirement. By pre-retirement, most people achieve financial freedom. Their homes are paid for and their children are living independently. At retirement, the focus should shift to preservation of wealth.

While financial pressures are greatest early on in the life cycle, the more you save and invest early in life, the greater the likelihood that you will have enough saved for retirement. Earnings on money saved and invested early will have longer to compound, which can make a dramatic difference over time.

Most people lack the discipline to begin saving early in life, but they are more likely to do so if they have a financial strategy that identifies their goals and what they need to do to get there. You're more likely to save if you know what you're saving for.

Matthew D. Jantzen is a representative with John Hancock Financial Network, 700 Cedar Lake Blvd., Oklahoma City, Okla. 73114 and can be reached at 405-475-7844 or mjantzen@jhnetwork.com.

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