Nursing Continues A Tradition of Legislative Success

The first time nursing achieved legislative success in Texas was at the 1909 Legislature. Four nurses from the recently formed Graduate Nurses’ Association of Texas (precursor to Texas Nurses Association) were selected by their peers to travel to Austin to present testimony on a proposed bill for state registration of nurses. The legislation passed and became the State Nurses’ Registration Act. Nursing now had its first legal structure for defining and regulating the practice of professional nursing.

The State Nurses’ Registration Act would create the Board of Nurse Examiners for the State of Texas (now named the Board of Nursing) for examination and licensing of nurses – to provide for proper registration, revocation of certificates, and fix suitable penalties for violating the law.

By 1911, nursing began to look at state inspections of the nursing schools as a means of raising education standards anddifferentiating trained nurses from those who only claimed to be. No provision had been made in the original 1909 bill for inspecting or accrediting nursing schools, and nursing instruction in the early 1900s was inconsistent. While only two nursing schools existed in Texas prior to 1900, the advantages of having a nursing school in conjunction with a hospital were soon broadly recognized. Schools of nursing proliferated as hospitals grew in numbers.

In 1913, the same year that the Ford Motor Company installed its first assembly line, nursing in Texas was looking at the standards for nursing schools. Entrance requirements were raised, a standard three-year course of study and an 8-hour day was secured for students, curriculum was made uniform, and better preparation for teaching and supervision was implemented. Nursing was making progress as a profession.

Then, through continued success at the 1923 Texas Legislature, nursing achieved a Revised Nurses’ Registration Bill. It made state registration compulsory, and provided for the inspection and accreditation of schools of nursing. This was to be accomplished by a newly named education

Outrageous, claims Texas Nurses Association, that two nurses face criminal indictments in Winkler County for being patient advocates.

In response – and in support, TNA establishes a legal defense fund.

Read more, page 11.

Inside this Issue

TNA Districts and Presidents .......................... 2
Creating a Less Punitive Environment for Nurses .......................... 3
In Setting Safe Staffing Levels, Nurses Know Best .......................... 5-9
Cancer Survivorship Crosses Nursing Specialties .................................. 15-16
CASA Volunteers Give Help and Hope to Children in Need .......................... 17
TNA’s Annual Nursing Leadership Conference .......................... 18-19
Membership Application .......................... 22

Join the Texas Nurses Association Today!

Application on page 22.
TNA Districts and Presidents

1: Patricia Shanaberger
10110 Woodway Dr.,
El Paso TX 79925
Phone: 915/831-4495
Email: pshanaber@epcc.edu

2: Heidi Taylor
Phone: 806/654-3500
Email: htaylor@wtamu.edu

3: Sandi McDermott
Phone: 972/566-7187
Email: sandi.mcdermott@hcachargete.com
District Staff: Renee James
Phone: 817/249-5071
Email: tnas3@usapathway.com
Web site: www.tnas3.org

4: Colleen Hines
Phone: 972/348-1614
Email: chten@sbcglobal.net
District Staff: Pat Pollock
Phone: 972/435-2216
Email: d4tna@flash.net
Web site: www.tnads4.org

5: Serena Bumpas
Phone: 409/772-8390
Email: sbumpus@seton.org
Phone: (512) 324-1000 ext. 88238

6: Ellarene Duis Sanders
Phone: 432/381-2429
Email: sghreem@hughes.net

7: Megan Mosley
Phone: 432/737-1000
Email: jemt@windstream.net

8: Gayle Dasher
Phone: 210/705-6266
Email: gdasher@satx.rr.com
Web site: www.texasnurses.org/districts/08

9: Mary Holt Ashley
Phone: (832) 566-2010
Email: maryashley2@comcast.net
District Staff: Melanie Tuong
Phone: 713/523-3619
Email: tnadistrict9@gmail.com
Web site: www.tnads9.org

10: Barbara Hills
Phone: 254/420-1231
Email: TNA District10@gmail.com

11: Michelle Villegas
Phone: 940/397-4602
Email: michelle.villegas@mwsu.edu

12: Patricia Morrell
Phone: 936/212-7222
Email: patricia.morrell@mhbb.org

13: Vacant

14: Joe Lacher
Phone: 956/882-5089
Email: joe.lacher@utb.edu

15: Andrea Kerley
Phone: 325/670-4230
Email: akerley@hendrickhealth.net

16: Martha Sleutel
Phone: 325/942-2060 ext. 258
Email: martha.sleutel@angelo.edu

17: Nancy Goodman
Phone: 361/825-2607
Email: nancy.goodman@tamucc.edu
Web site: www.texasnurses.org/districts/17

18: Patty Freier
Phone: 806/797-8120
Email: pfreier@covhs.org

19: Nina Wallace-Gross
Phone: (903) 877-5102
Email: nina.wallace@uthct.edu
Web site: www.texasnurses.org/districts/19

20: Denise Neil
Phone: 361/570-4277
Email: pfeilil@uhv.edu

21: Sherrie Harris
Phone: 432/381-2429
Email: sghreem@hughes.net

22: Toni McDonald
Phone: 936/544-5132
Email: tmdonald@windstream.net

23: Inger Zerucha
121 Oak Isle Dr.,
Longview, TX 75605
Phone: (903) 315-2632
Email: zinger65@sbcglobal.net

24: Esmeralda Garza
Phone: 956/683-3143
Email: maila@southtexascollege.edu

25: Kim Penny
Phone: 903/832-5565 ext. 3205
Email: ksperry62@aul.com

26: Esmeralda Garza
Phone: 956/683-3143
Email: maila@southtexascollege.edu

27: Kim Penny
Phone: 903/832-5565 ext. 3205
Email: ksperry62@aul.com

28: Patty Freier
Phone: 806/797-8120
Email: pfreier@covhs.org

29: Sally Durand
Phone: 281/736-3634
Email: su durand@alvincollege.edu

30: Kim Catlin
Phone: 903/466-6982
Email: kcatlin@ntrc.edu

31: Mary Holt Ashley
Phone: (832) 566-2010
Email: maryashley2@comcast.net
District Staff: Melanie Tuong
Phone: 713/523-3619
Email: tnadistrict9@gmail.com
Web site: www.tnads9.org

32: Patricia Morrell
Phone: 936/212-7222
Email: patricia.morrell@mhbb.org

33: Vacant

34: Joe Lacher
Phone: 956/882-5089
Email: joe.lacher@utb.edu

35: Andrea Kerley
Phone: 325/670-4230
Email: akerley@hendrickhealth.net

36: Martha Sleutel
Phone: 325/942-2060 ext. 258
Email: martha.sleutel@angelo.edu

37: Nancy Goodman
Phone: 361/825-2607
Email: nancy.goodman@tamucc.edu
Web site: www.texasnurses.org/districts/17

38: Patty Freier
Phone: 806/797-8120
Email: pfreier@covhs.org

39: Mary Holt Ashley
Phone: (832) 566-2010
Email: maryashley2@comcast.net
District Staff: Melanie Tuong
Phone: 713/523-3619
Email: tnadistrict9@gmail.com
Web site: www.tnads9.org

40: Contact TNA
Phone: 800/862-2022 ext. 129
brichley@texasnurses.org

Web site: www.texasnurses.org/districts/18/

19: Nina Wallace-Gross
Phone: (903) 877-5102
Email: nina.wallace@uthct.edu
Web site: www.texasnurses.org/districts/19

20: Denise Neil
Phone: 361/570-4277
Email: pfeilil@uhv.edu

21: Sherrie Harris
Phone: 432/381-2429
Email: sghreem@hughes.net

22: Toni McDonald
Phone: 936/544-5132
Email: tmdonald@windstream.net

23: Inger Zerucha
121 Oak Isle Dr.,
Longview, TX 75605
Phone: (903) 315-2632
Email: zinger65@sbcglobal.net

24: Esmeralda Garza
Phone: 956/683-3143
Email: maila@southtexascollege.edu

25: Kim Penny
Phone: 903/832-5565 ext. 3205
Email: ksperry62@aul.com

26: Esmeralda Garza
Phone: 956/683-3143
Email: maila@southtexascollege.edu

27: Kim Penny
Phone: 903/832-5565 ext. 3205
Email: ksperry62@aul.com

28: Patty Freier
Phone: 806/797-8120
Email: pfreier@covhs.org

30: Kim Catlin
Phone: 903/466-6982
Email: kcatlin@ntrc.edu

31: Mary Holt Ashley
Phone: (832) 566-2010
Email: maryashley2@comcast.net
District Staff: Melanie Tuong
Phone: 713/523-3619
Email: tnadistrict9@gmail.com
Web site: www.tnads9.org

32: Patricia Morrell
Phone: 936/212-7222
Email: patricia.morrell@mhbb.org

33: Vacant

34: Joe Lacher
Phone: 956/882-5089
Email: joe.lacher@utb.edu

35: Andrea Kerley
Phone: 325/670-4230
Email: akerley@hendrickhealth.net

36: Martha Sleutel
Phone: 325/942-2060 ext. 258
Email: martha.sleutel@angelo.edu

37: Nancy Goodman
Phone: 361/825-2607
Email: nancy.goodman@tamucc.edu
Web site: www.texasnurses.org/districts/17

38: Patty Freier
Phone: 806/797-8120
Email: pfreier@covhs.org

40: Contact TNA
Phone: 800/862-2022 ext. 129
brichley@texasnurses.org

Web site: www.texasnurses.org/districts/18/
Creating a Less Punitive Environment for Nurses

Not only did the IOM's report To Err is Human (1999) deliver a wake-up call as to the prominence of errors in health care, it also challenged health care to rethink its perspective on errors. Conventional wisdom had suggested that errors were made by individuals, so if you found the person who made the error and corrected them, you fixed the problem. However, people don’t usually make “mistakes” on purpose (then it isn’t a mistake), so it is not a matter of education, of knowing better. It is a matter of being a fallible human being in a complex environment with many opportunities for error.

Some errors can be designed out of a process. For example, some things should never be connected to each other. Leaded gasoline doesn’t belong in a no-lead tank, and because some individuals have made this error, the gas receptacle for no-lead tanks has been designed smaller than a leaded nozzle. The two don’t fit, thus preventing one from filling up with the wrong kind of gas.

Unfortunately, we have not done as well in health care. Universal “luer locks” have simplified tubing connections to a fault – feeding tubes, epidural infusions, and blood pressure monitors can be connected to intravenous (IV) lines. Nurses are educated that feeding tubes should never be attached to IV lines, yet such errors have occurred with disastrous results. Experts in human factors engineering look for ways to prevent human error by designing systems, such as different size gas nozzles, that interrupt the error. If feeding tube connectors were incompatible with IV lines, they could not be connected – the error would not occur. (There are ongoing efforts to eradicate universal connectors and thereby prevent tubing misconnections).

When the focus shifts from the individual who made the error (e.g., the nurse who administers a wrong medication) to factors contributing to the error (the medication was a look alike medication stored in Pyxis® bin adjacent to the ordered medication), fixing the problem goes beyond blaming the nurse for not following the seven rights of medication administration, to investigating how the hospital can ensure look alike medications are not stored in adjacent bins so another nurse does not grab the wrong drug. How the error occurred is more important that who made the error because knowing “how” enables a response that may prevent recurrence.

In addition, a focus on who made the error inhibits reporting of errors due to fear of repercussions either for oneself or one’s colleague. Yet, the only way to prevent errors and design systems to prevent errors is to know about errors and near misses. A culture of safety depends on widespread reporting of errors and near misses so that systems and processes contributing to the error can be identified and corrected. We need the opportunity to learn from our mistakes.

The Texas Nurses Association has worked with the Texas Board of Nursing (BON) to promote movement toward a culture of safety and a shift from individual blame to problem solving and prevention. That is, when an adverse event occurs due to a nurse's error, the focus should be on identifying and fixing deficiencies in the system, not punishing the nurse. This legislative session, TNA initiated legislation to change the Nursing Practice Act to provide the BON with less punitive disciplinary options when a nurse commits minor violations. The BON’s mission is: “...to promote and protect the welfare of the people of Texas by ensuring that each person holding a license as a nurse in the State of Texas is competent to practice safely.”

Additional options will enable the BON to focus its time and efforts on those nurses who truly pose a risk to public safety rather than those competent practitioners who have made errors within imperfect systems. Senate Bill 1415 and companion House Bill 1128 create the opportunity for the BON to take corrective action as an alternative to disciplinary action for minor violations. Because corrective action would not be considered discipline, it would not be public information and would not be displayed on the nurse’s license. It is likely that the BON would utilize corrective action for nonpractice violations – those remedied by a fine or remediation.

Creating a Less Punitive Environment continued on page 4
secretary, A. Louise Dietrich, who would visit all nursing schools annually for the purpose of evaluation. With the legislation, nursing now had a legal means for uncovering inferior education in schools.

Another 25 Years of Legislative Advocacy

If the first 25 years of professional nursing in Texas were bountiful in achievements, the last quarter of nursing’s 100-year history is no less so. Legislative advocacy by Texas Nurses Association has consistently achieved elevated practice and education standards – year after year, legislative session after legislative session. From the early days of hospital nurse “training” when requirements were simple and included an age range of 19 to 35 years, good moral character, and success upon examination in reading, penmanship and simple arithmetic, nursing’s come a long way. Through legislative advocacy, Texas nurses have:

Workplace Safety and Safe Patient Handling

- First-in-the-nation Safe Patient Handling law that requires hospitals and nursing homes to adopt policies minimizing manual lifting.
- Required hospital policies that address violence and workplace safety for nurses.

Advocacy and Whistle-blower Protections

- The right to request safe harbor peer review protection when refusing to engage in conduct believed not in the best interest of patients.
- Whistle-blower protection when reporting concerns about patient care within a facility or to accrediting agencies; or when reporting other professionals for unsafe care.
- Protection from receiving a “bad employment reference” ("nurse does not follow instructions") when refusing to engage in conduct believed not in the best interest of patients.

Legislative Investment in Nursing Education

- Nursing schools received more than $55 million to increase enrollments and graduations to ensure nursing thrives as a profession.
- Research of nursing supply and demand through the Center for Nursing Workforce Studies.

And… nurse title protection, prescriptive authority and Medicaid reimbursement for advanced practice nurses, licensure mobility for nurses afforded through the Nurse Licensure Compact, and a peer assistance program for nurses experiencing chemical dependency and mental illness.

The Year 2009

With the 81st Regular Texas Legislative Session having come to an end on June 1, nursing can add to its list of achievements for practice. With passage of SB 476, the Safe Hospital Staffing Act, nurses gained a greater voice in the decisions of nurse-to-patient staffing levels in hospitals. They gained an elevated role in assuring hospital accountability for safe and effective staffing through a new required direct involvement with hospital governing boards that must report nurse staffing information to the Texas Department of State Health Services. Through representation on a hospital Nurse Staffing Committees, nurses can help select the nurse-sensitive patient outcome measures that will be used to evaluate the effectiveness of the staffing plan. And, they can decline working mandatory overtime beyond a scheduled shift.

In this issue of TEXAS NURSING Voice, a continuing nursing education activity is offered on the Safe Hospital Staffing Act (see page 5). All readers can take advantage of the information on the new Texas law. Anyone wanting contact hours for the CNE activity can visit Texas Nurses Association online at texanurses.org. ★

example, a nurse applying for Texas licensure forgets to acknowledge on her application that 28 years ago while in college she was arrested for participating in a public demonstration that became rowdy. When the BON completes the criminal background check, they note that the nurse’s application omits this information – technically she has misrepresented herself to the BON and may be subject to disciplinary action. Yet, the nurse has had no practice or other legal issues in 28 years. Under this new statute, the BON could elect to take corrective action and issue a fine for not disclosing the previous legal history.

This legislation also enables the BON to conduct a pilot to evaluate the feasibility of using deferred disciplinary action as an alternative to disciplinary action for minor violations. Deferred disciplinary action would not apply to those cases in which the BON would propose to issue a reprimand, or to deny, suspend or revoke a license. For example, a nurse may be reported to the BON for making a fairly serious error. Upon investigation, the BON learns of significant system issues that contributed largely to the nurse’s error. The BON believes the nurse is a competent and safe practitioner whose practice poses no public threat. A deferred disciplinary action option would allow the BON to impose conditions, such as remedial education or supervision as a condition of probation. During this period, the BON’s action would not be confidential. Once the probationary period was completed, the BON could dismiss the complaint against the nurse and the deferred disciplinary action by the BON would become confidential and would not be displayed on the nurse’s license.

The BON has a responsibility to ensure that nurses who practice are competent and safe. This legislation contributes to that effort by enabling the BON to consider alternatives to disciplinary action for minor violations without permanently affecting the nurse’s license and by freeing up resources for the BON to focus on those infractions that may pose a true risk to patient safety. It represents one more step toward acknowledging the human nature of nurses and errors and assuring nurses that they will not be condemned for making a minor mistake.

Other Nursing Practice Act (NPA) changes include making confidential certain information (i.e. medical information) provided on licensure application and renewal forms and personal contact information provided for disaster relief programs. The NPA also now defines how the BON can utilize physical and psychological evaluations and the nurse’s rights in the process. ★

Creating a Less Punitve Environment continued from page 3
How to Earn Continuing Nursing Education Credit

1) The article, In Setting Safe Staffing Levels, Nurses Know Best, is presented as information only in this issue of Texas Nursing Voice. Continuing nursing education credit may also be earned. To receive a certificate of successful completion for 1.0 contact hour, visit www.texansc.org and follow the online prompts.

2) Once you complete the registration form, you may use your Visa® or MasterCard® to pay the processing fee.

- $10 for TNA members
- $15 for non-members

3) Once payment is made, you will receive a confirmation that will allow access to the online activity.

4) Read the article.

5) Take the post-test. To successfully complete the post-test, you must achieve a score of 80% or better.

6) Complete the evaluation tool.

7) You will then be able to print your Certificate of Successful Completion for 1.0 contact hour.

Accreditation Statement
The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Disclosure to Participants

1–Requirements for successful completion:
To receive credit for this continuing nursing education activity, the reader must:

- Read the article (either below or online).
- Complete the registration form (online only).
- Pay the appropriate processing fee (online only).
- Complete the activity evaluation tool (online only).
- Achieve a score of 80% on the post-test.

Once successful completion has been verified, a “Certificate of Successful Completion” will be awarded for 1.0 contact hours.

2–Conflict of interest: A conflict of interest occurs when an individual has an opportunity to affect or impact educational contents with which he or she may have a commercial interest or financial relationship. All planning committee members and the author are required to disclose any potential or actual conflict of interest with any commercial entity that may have an interest in the activity’s educational contents. The planners and the author of this CNE activity would like to disclose that they are employed by the Texas Nurses Association.

3–Commercial support: This educational activity did not receive any commercial support.

4–Non-endorsement of products: TNA/F’s ANCC accreditation status refers to the continuing nursing education activity only, and does not imply either TNA/F’s or ANCC’s real or implied endorsement of any product, service, or company referred to in this educational activity.

5–Off-label product use: This education activity does not include any information about off-label use of a product for a purpose other than that for which it is approved by the U.S. Food and Drug Administration (FDA).

6–Expiration date: This activity expires July 20, 2011

Questions
E-mail any questions to: CNE@texansc.org; or phone 512.452-0645 extension 3. (If you experience technical difficulty, please use extension “0” to get help.)

Educational goal/purpose
The purpose of this educational activity is to provide nurses in hospital settings with current information about the Safe Hospital Staffing Act (SB 476), the new Texas law that addresses safe staffing for effective patient care.

Learning objectives
Upon completion of this learning activity the nurse should be able to:

1. Identify evidence supporting the relationship between adequate staffing and patient outcomes.
2. Discuss two approaches considered by legislatures to achieve adequate nurse staffing.
3. Outline three factors that can influence the adequacy of staffing.
4. Define three nurse sensitive patient outcomes that can be used to evaluate the adequacy of staffing.
5. Describe key provisions in the Safe Hospital Staffing Act (SB 476) that increase the influence of nursing in developing, monitoring, evaluating, and reporting staffing plans.
6. Describe provisions in the Safe Hospital Staffing Act that assure hospital accountability for the adequacy of staffing.

Introduction
It’s no secret that safe staffing is one of the main concerns of nurses working in acute care hospitals, and for good reason. Nurses care about their patients’ outcomes, and nurse staffing levels are inextricably linked to such outcomes. In addition, when staffing levels are inadequate, nurses can experience fatigue and burnout, and exhausted nurses are more prone to commit errors affecting patient safety. Therefore, nurses, hospitals, and the public have a vested interest in assuring adequate staffing in hospitals. But what is “adequate” or “safe” staffing, and who should define the criteria for making that determination?

Several states have grappled with this issue in their legislature. Two basic approaches have been considered: mandated fixed nurse to patient ratios and mandated nurse staffing plans. Only California, the first state to legislate nurse staffing requirements (1999), has passed mandated fixed nurse to patient ratio legislation in which the number of patients a nurse may be assigned is determined by regulation. In contrast, the mandated staffing plan approach typically involves nurses (e.g., representatives from various clinical areas) and leadership (e.g. management, infection control, quality, education) in developing staffing plans to guide patient care assignments. At least eight states have passed legislation mandating nurse staffing plans, including Texas. In fact, Texas was the first state to adopt regulations requiring hospitals to establish nurse staffing plans and the first state to actually implement nurse staffing requirements in 2002 (California did not implement its mandated ratio law until 2004). Senate Bill 476 was passed by the Texas legislature this past legislative session and will become effective on September 1, 2009. SB 476 builds upon existing Hospital Licensing Rules (§133.41), enhances the role of direct care nurses in determining staffing plans, and promotes greater hospital accountability for adequate staffing. Nurses informed about new staffing requirements will be in the best position to collaborate with others in their hospitals to achieve staffing plans that meet the needs of patients and promote a positive work environment. The purpose of this article is to provide nurses with current information about Texas’ Safe Hospital Staffing Act.

Background
Staffing concerns peaked during the 1990s – a decade of turmoil in the health care industry as managed care changed the rules for payment of health care. More services were shifted to outpatient settings. Hospitals struggled financially and responded with efforts to reduce costs of providing care. Re-engineering of patient care resulted in new patient care delivery models, e.g. “patient focused care”, that made greater use of nurse extenders – unlicensed assistive personnel. Such models reduced the utilization of registered nurses in hospitals and hospital vacancy rates declined, nursing schools reduced enrollments, and the nursing shortage abated. While, there was unrest among nurses who felt new delivery models did not provide an adequate level of professional nurse staffing, there was very little hard evidence to support this belief.

In response to nurses’ concerns, Congress directed the Department of Health and Human Services to ask the Institute of Medicine (IOM) to study the relationship of quality of nursing care, patient outcomes, and nursing outcomes (e.g. work-related stress and injuries) related to nurse staffing levels and skill mix. The final report, Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?, published in 1996 (Wunderlich, Davis, & Sloane), was unable to reach any conclusions regarding these relationships due to the overwhelming lack of data related to quality and outcomes of hospital care. Final recommendations identified the need to generate quality information as a priority.

The committee concludes... that high priority should be given to obtaining empirical evidence that permits one to draw conclusions about the relationship of quality of inpatient care and staffing levels and mix (p. 8).
system as well as nurse staffing will provide the greatest benefit to the patient.

Renowned expert on the topic of RN staffing and patient outcomes, Linda Aiken PhD, RN, FAAN, would likely agree. At the 2009 NDNQI conference in Dallas, TX, she stated that the nurse’s practice environment was emerging as a core indicator in improving nurse recruitment and patient ratios. She indicated that medical-surgical nurses providing care for eight patients could achieve the same outcomes as nurses providing care to four patients when the practice environment provided appropriate support to the RN, e.g., collaborative interdisciplinary relationships, appropriate support staff and technology, etc.

While virtually every study conducted has supported the positive influence of RN staffing on patient outcomes, not one study has suggested an RN to nurse patient ratio. This is because there are a number of other variables – characteristics of the nurse, patient, hospital, and practice environment – that affect the “ideal” ratio. “A nurse is a nurse is a nurse” does not hold true – nurses vary in their experience, age, education, skill level, and readiness to safely manage a patient assignment. A nurse with 10 years of experience in medical-surgical nursing would be able to manage a more complex patient assignment than new graduate nurse who just completed orientation. Patients also differ in their care requirements – a patient who was just transferred from intensive care will likely need a different level of nursing care than a patient who is ready to be discharged home. Likewise, hospitals differ – a telemetry unit in quaternary medical center that provides heart transplants and bypass surgery is much different from a small rural hospital that does not provide cardiology procedures. Finally, characteristics of the practice environment will affect appropriate assignments (e.g. use of technology to optimize efficient nursing care, collaborative relationships with physicians and ancillary staff, streamlined work processes to eliminate redundancy, involvement of nurses in practice decisions and problem solving, number and type of support staff). In order to provide the right staffing levels and mix, all of these components must be considered.

Legislative and Regulatory Approaches

The evidence relating adequate nurse staffing to patient outcomes is well established. As individual legislatures and regulatory agencies consider the best way to achieve adequate staffing, two basic approaches have been adopted: mandatory fixed ratios and mandatory staffing plans.

In the 1990s as changes in inpatient nurse staffing occurred, California considered a legislative solution – a bill mandating nurse to patient ratios was introduced in the early 1990s. The bill was defeated in 1995, but the Department of Health Services proposed hospital licensing rules to designate the number of patients a licensed nurse could be assigned to care for in various inpatient hospital units. The rules were implemented in 2004; LVNs may account for up to 50% of the licensed nurse to patient ratio.

The beginning of the new millennium brought with it the threat of a nursing shortage unlike any experienced before. The Texas Nurses Association (TNA) identified the threatening fragmentation of patient care and the demand for access to quality health care and pulled together a group of stakeholders to prepare to address the shortage. An effective response would require both increasing the production of nurses, which had dwindled during the 1990s, as well as improving the nurse’s practice environment.

Recognizing this, in 2002 as a part of addressing the nursing shortage, TNA and the Texas Hospital Association (THA) jointly petitioned the Department of State Health Services (DHS) to strengthen its rule governing nurse staffing and support the development of a “safe hospital” staffing model. As part of their effort, the Department of State Health Services adopted hospital nurse staffing rules which set standards for staffing including a process requiring significant input from direct care nurses through a nurse staffing advisory committee. These rules were updated in 2007 increasing the proportion of direct care nurses who served on the committee.

Following Texas’ lead, several other states increased oversight of nurse staffing in hospitals. In 2002, Oregon became the first state to pass legislation requiring the mandated staffing plan approach. Other states followed: Illinois (2007), and Connecticut, Washington, and Ohio in 2008, and Nevada in 2009 (see Table). Each of these states achieved staffing requirements through a process involving stakeholders including the state nurses and hospital associations.

The number of nurses to patient ratios has been introduced in several states in recent years, none, except California have adopted this approach. Besides being unsupported by research, a key reason mandated fixed nurse to patient ratios have not been successful is the inflexibility of this approach – it assumes all nurses, patients, nurses/ hospital are equal, therefore one number will fit all situations. For example, if the required ratio on a telemetry unit is one nurse to four patients and there are eight patients, each nurse must be assigned four patients, even if, based on patient complexity and expertise, it would be more appropriate to assign three patients to one nurse and five patients to the other. Secondly, it fails to account for dynamic changes in the inpatient practice environment, and there is no flexibility to respond to changes in patient conditions requiring redistribution of resources. For example, a 25 bed medical-surgical unit is full and staffed with five nurses each with their ratio of five patients. One patient develops a gastrointestinal bleed and requires a nurse to be at the bedside constantly to run fluids, transfuse blood, etc. until the patient is stable. Under this intensive care. The nurse cannot redistribute his patients to other staff (e.g. one patient to each of the other four nurses) because each nurse is already at ratio.

A Success Story: The Safe Hospital Staffing Act

Senate Bill 476 represents background work of TNA's Staffing Task Force (2007-2008) who evaluated implementation of existing regulations and current issues in nurse staffing, and made recommendations via a resolution at the TNA 2008 House of Delegates. The resolution directed TNA to support the development of the direct care nurse in shared decision making around staffing decisions, explore ways to strengthen the Hospital Nurse Staffing Rules, and to support strategies to evaluate compliance and effectiveness of the staffing rules. TNA's Council of State Health Services adopted these directives. Safe staffing approaches implemented in other states were reviewed and compared to identify best practices for potential adoption in Texas. A decision to move from staffing regulations (licensing rules) to statute was determined to be the appropriate next step in strengthening Texas' nurse staffing requirements. A proposal addressing issues...
Setting Safe Staffing Levels continued from page 6

THA was identified as a key stakeholder—any changes to existing regulations were most likely to succeed if they reflected negotiations with a major stakeholder. Negotiations with THA ensured over 6 months to solidify an agreed proposal which THA could actively support. Negotiations with THA ensured over 6 months to solidify an agreed proposal which THA could actively support. The resultant legislation, SB 476 carried by Senator Jane Nelson (R-Flower Mound) and identical House Bill 591 carried by the two nurses in the House—Donna Howard (D-Austin), former critical care nurse, and Susan King (R-Abilene), a practicing surgical nurse—was actively supported by 18 Texas nursing organizations as well as THA and passed both chambers unanimously. SB 476 was signed by the Governor on June 19 and will become effective September 1, 2009.

Provisions for Safe Staffing

While SB 476 builds upon the existing Nurse Staffing Rules currently within the Hospital Licensing regulations, several key changes strengthen the nursing’s influence and the hospital’s accountability for adequate staffing.

The hospital’s governing board becomes responsible for nurse staffing through a requirement that the board adopt a policy that designates a process for developing, implementing and enforcing a unit and shift-based staffing plan. A hospital governing board is responsible for overseeing the mission, plans and policies of the organization. They are responsible for ensuring the organization has adequate resources and complies with applicable rules and regulations. Ultimately, the board is accountable to its owners—stockholders if for-profit and the public with nonprofits. Participation of the governing board is significant because the hospital administrator or chief executive officer (CEO) reports to the board. SB 476 bumps the significance of nurse staffing to the highest level of authority in a hospital—its governing board.

By requiring the staffing plan to be not only developed, but also implemented and enforced, the board cannot merely adopt a policy to sit in a three ring binder on the shelf until the next Joint Commission survey. Instead the plan must be fully executed. Further, the plan must:

- reflect current national standards, such as those developed by the Emergency Nurses Association, American Association of Critical Care Nurses, and Association of Women’s Health, Obstetric and Neonatal Nurses
- set minimal staffing levels for each patient care unit, each shift, based on multiple nurse, patient, and hospital considerations (for example experience and expertise of the nurse, acuity and intensity of the patient, scope of services of the hospital) and the nursing assessment
- include a method of adjusting the plan to meet patient needs (for example an acuity system that measures which patients may need more intense nursing care or additional nursing time)
- include a contingency plan in the event patient care needs exceed resources (for example plans to access additional staff through outside agencies, plans to reduce admissions by diverting ambulance traffic from the emergency department, or plans to triage ICU patients for transfer to stepdown units)

### Table 1

| Comparison of Recent State Legislation Mandating Hospital Nurse Staffing Plans |
|---------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| 1. Where Staffing Addressed      | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| In statute                       |                 |                 |                 |                 |                 |                 |                 |
| In regulations only              | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 2. Role of Hospital Board       |                 |                 |                 |                 |                 |                 |                 |
| Adopts policies governing        | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Receives plan evaluation         |                 |                 |                 |                 |                 |                 |                 |
| Line up state regulations governing staffing met | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 3. Committee Composition        |                 |                 |                 |                 |                 |                 |                 |
| Standing committee that reports to hospital board | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 50% staff nurses                 | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Staff nurses elected by staff nurses | ✔             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| CNO on Committee                 | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Meets on paid time               |                 |                 |                 |                 |                 |                 |                 |
| 4. Committee Role               |                 |                 |                 |                 |                 |                 |                 |
| Develops plan for hospital       | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Advisory                        |                 |                 |                 |                 |                 |                 |                 |
| Weight to be given to recommendations | ✔             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Significance of registered nurse weight | ✔             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Significance of registered nurse consideration | ✔             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| If plan not adopted, CEO provides written explanation | ✔             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Significant consideration        |                 |                 |                 |                 |                 |                 |                 |
| Evaluates Plan                   |                 |                 |                 |                 |                 |                 |                 |
| Reports to Hospital Board        | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 5. Plan Components              |                 |                 |                 |                 |                 |                 |                 |
| Factors to be considered in developing plan set out such as census, admissions and discharges, skill mix, etc | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Plan sets minimum staffing levels on per unit basis | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Plan reflects current standards established by private accreditation organizations or governmental entities | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Plan is Unit-Based               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Plan is shift-based              | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Process for adjusting plan       | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Contingency plan for unexpected coverage needs | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Identify practice for use of temporary personnel | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 6. Input & feedback from nurses  |                 |                 |                 |                 |                 |                 |                 |
| Process for input                | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Process for response             | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 7. Non-retribution and whistleblower protections for nurses reporting staffing concerns | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 8. Process for new nurses can initiate procedure to limit hospital admissions | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 9. Risk evaluation & plan        |                 |                 |                 |                 |                 |                 |                 |
| Hospital must define process for | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Annual                          |                 |                 |                 |                 |                 |                 |                 |
| Semi-annual                     | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Nurse sensitive outcome measures used to evaluate | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Committee selects                |                 |                 |                 |                 |                 |                 |                 |
| Committee does evaluation        | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 10. Posting requirements         |                 |                 |                 |                 |                 |                 |                 |
| Staffing plan                    | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Staffing – plan levels           | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Staffing – actual levels         | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Staffing schedules               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Posted for nurses                 | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Posted for public                 | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 11. Budget considerations       |                 |                 |                 |                 |                 |                 |                 |
| Plan used as component of setting staffing budget | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Finance may be considered in developing plan | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| 12. Acuity model required        | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |
| Method for adjusting based on patient needs | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               | ✔               |

**Notes:**
- NV: Applies only to hospitals >70 beds in counties with populations of 100,000 or more
- VI: Only requires hospitals submit a core staffing plan to the department of health in January of each year.
- PF: Precludes for public access to nurse to patient ratio information under patient’s Bill of Rights
- NI: Requires posting of staffing information each shift, information is reported and made available to public quarterly

Texas Nursing Voice • Page 7
The nurse staffing committee is strengthened by enabling direct care nurses to select their representatives, involving the chief nursing officer (CNO) as a committee member, and requiring the committee to report directly to the hospital board. Since 2002, Texas hospitals have been required to have staffing committees that included direct care nurses, representation from multiple areas of nursing practice, and a nurse from infection control, quality assurance, or risk management. This membership was intended to provide the committee with the knowledge and expertise needed to monitor and evaluate the hospital’s staffing plan. Now, all direct care nurses will have a greater voice on the committee through the direct care nurses they select to represent them. Direct involvement of the CNO on the committee will strengthen the status of the committee and supports a collaborative staffing decision making process. Finally, the proportion of direct care nurses was increased to 60% from 50%.

The nurse staffing committee has primary responsibility for recommending, monitoring, and evaluating the nurse staffing plan. While the committee’s primary responsibility has been somewhat unclear in the past, the committee now has a more defined role in developing a recommended plan that must be given significant consideration when the hospital adopts the plan. The committee also has a powerful voice in its responsibility for evaluating the effectiveness of the plan. The hospital board remains involved as the nurse staffing committee provides at least semi-annual reports to the hospital board to stay informed of staffing issues and variances. Not only will the report include the committee’s evaluation of the effectiveness of the staffing plan and aggregate variances between planned and actual staffing. Significant or frequent variances may indicate that the hospital is not using the staffing plan to guide the assignment of nurses hospital wide as intended and is not complying with the statute. This process enables the hospital board to stay informed of staffing issues affecting the quality of patient care and to take action as necessary.

Additional hospital accountability for establishing an adequate staffing plan includes required reporting. The hospital must have a policy to make the staffing plan and current staffing levels available to nurses on each patient care unit, each shift. Nurses would be immediately aware of staffing variances and can report concerns to the committee. The hospital must also consider the staffing plan as a component in setting the staffing budget – staffing cannot be solely driven by budget, rather the budget must consider what is needed for adequate staffing. Finally, the hospital will report certain nurse staffing information to the Department of State Health Services as part of its annual hospital survey process.

Conclusion

Texas’ Safe Hospital Staffing Act provides a structure and process for nurses and hospitals to work together in designing staffing plans to provide for the unique needs of their patient population. A successful staffing committee will need the support of hospital leadership as well as direct care nurses. Leadership will need to promote shared decision making and collect and provide data regarding staffing variances, patient outcomes, and finances to the direct care nurse committee members. Direct care nurses will need to be willing to serve as representatives for their peers, share staffing concerns, and participate in problem solving efforts with the committee. A shared goal of achieving the most appropriate staffing considering characteristics of the specific hospital, nurses, and patients should guide committee decision making. An engaged hospital board will seriously consider staffing committee reports in the context of patient safety and quality care. The eventual effectiveness and success of the committee will be demonstrated in the patient outcomes achieved – the evidence is indisputable: adequate staffing is a prerequisite to positive patient outcomes.★

References


The Safe Hospital Staffing Act resulted from the contributions of a number of nurses from across Texas, including members of two Texas Nurses Association committees – TNA Staffing Committee and TNA Governmental Affairs Committee. For their efforts, we are grateful.

TNA Staffing Committee members:

- Mary Clark Robinson, PhD, RN-BC, Chair
- Mari Grace Cuellar, BSN, RN
- Candice Ward-Herman, MSN, RN, C-NE
- Judith Ann Krupala, MSN, RN, C-NE, FNP-BC
- Martha Helen Myers, RN
- Denise Neill, PhD, RN
- Elizabeth Sjoberg, JD, RN
- Wilma Powell Stuart, PhD, MA, RN
- Cindy Diamond Zolnierenek, MSN, RN

TNA Governmental Affairs Committee members:

- Victoria England, MBA, RN, Chair
- Bobbie Ogg, MSN, RN
- Pat Morrell, MSN, RN
- Nancy Goodman, MSN, RNC
- Stan Harmon, MSN, RN, FNP-C
- Regina Jones Johnson, DrPH, MSN, RN
- Michelle Newsom, RN
- Lillian Sanchez, MSN, RN
- Shirley Morrison, MSN, RN, CS, OCN
- Jennifer Cook, PhD, MSN, MBA, RN
- Jessica Olivet, RN
- John Crossley, RN, PhD, MBA, MSN, CNA
- Susy Sportsman, PhD, RN
- Poldi Tschirch, PhD, RN
- Ruth Stewart RN, MS, FAAN
- Margie Dorman-O’Donnell, MSN, RN
- Fran Martin, MS, RN

ThePracticeofProfessionalNursing/PatientSafetyQuality/ NDNQI/NDNQI_1.aspx

Nursing Matters* fact sheets provide quick reference information and international perspectives from the nursing profession on current health and social issues.

Nursing Sensitive Outcome Indicators

Introduction

Along with health care reform, the quest for cost-effectiveness and quality of care and the growing sophistication of health care systems, has come an increased emphasis on evidence and outcomes. These elements, together with a growing concern about changes in skill mix, prompted nursing to focus on identifying outcome indicators sensitive to nursing inputs and staffing levels.

Nursing Sensitive Patient Outcomes

Outcomes define the end results of nursing interventions and are indicators of problem resolution or progress toward problem or symptom resolution. The ICNP® defines a nursing outcome as the measure or status of a nursing diagnosis at points in time after a nursing intervention, while nursing-sensitive outcomes are defined as changes in health status upon which nursing care has had a direct influence. Variables affecting patient outcomes include diagnosis, socio-economic factors, family support, age and gender, and the quality of care provided by other professionals and support workers.

Commonly Used Nursing Sensitive Outcome Indicators

The following patient outcomes are commonly used nursing sensitive indicators:

1. Patient complications, such as urinary tract infections, skin pressure ulcers, hospital acquired pneumonia and deep vein thrombosis/pulmonary embolism.
2. A group of exploratory measures, comprising upper gastrointestinal bleeding, central nervous system complications, sepsis and shock/cardiac arrest.
3. Complications among surgical patients such as wound infection, pulmonary failure and metabolic derangement.
4. Patient length of stay, and failure to rescue (failure to respond to patients’ urgent conditions such as shock, cardiac arrest and deep vein thrombosis, potentially resulting in increased morbidity and/or mortality).

In addition, an inventory of patient outcomes has been identified related to the scope of practice and staff mix in a health facility. These include:

- Symptom control and change in symptom severity.
- Functional status.
- Knowledge of condition and treatment.
- Patient satisfaction with care.
- Unplanned emergency department visits.
- Unplanned hospital readmissions.
- Strength of treatment alliance.

What is the Importance of Nurse Sensitive Indicators?

Use of nursing sensitive outcome indicators helps focus attention on the safety and quality of patient care and the measurement of care outcomes. It is important that nurses and health facilities collect data to monitor the ongoing cost and quality of patient care. Using nursing sensitive outcome indicators is crucial to effectively demonstrate that nurses make the critical, cost-effective difference in providing safe, highquality patient care.

The importance of articulating nursing sensitive quality indicators cannot be overstated. Such articulation and the correlation of nursing activities with health outcomes provide strong support for appropriate allocation of health care resources. For example, studies comparing staffing levels and patient outcomes show that when there are more registered nurses, patients’ experience fewer complications, shorter lengths of stay, decreased mortality rates and even lower overall costs. Similarly, a strong and consistent relationship has been found between nurse staffing and five patient outcomes in medical patients: urinary tract infections, pneumonia, length of stay, upper gastrointestinal bleeding and shock. This means higher levels of nurse staffing are associated with less adverse effects.

Conclusion

Nursing sensitive outcome indicators are intended to draw correlations between nursing intervention patients have received and their resulting health status. They are an attempt to measure the effectiveness of nursing care by measuring patient outcomes. Linkages are more easily seen when diagnosis, intervention and outcomes are identified. Since nurses are an integral part of the health care delivery system, nursing sensitive indicators capture what nurses do, what outcomes they achieve and at what cost. This is an important step in appropriate allocation of health care resources and in making nursing contribution to health care visible.

For further information, please contact: icn@icn.ch

The International Council of Nurses is a federation of more than 129 national nurses’ associations representing the millions of nurses worldwide. Operated by nurses for nurses, ICN is the international voice of nursing and works to ensure quality care for all and sound.

---

* Nursing Matters Fact sheet is reprinted with permission of the International Council of Nurses.

---

1. ANA Web site: http://www.nursingworld.org/mods/archive/mod30/cec213.htm
Texas Nurses Association Establishes Legal Defense Fund To Support Nurses Indicted for Being Patient Advocates

In Winkler County, a small West Texas county adjacent to the southeast corner of New Mexico, two registered nurses are facing criminal indictments because they wanted to advocate for their patients. The felony charge: misuse of official information. Under the Texas Penal Code, misuse of information is a third-degree felony that carries the potential for two-to-ten years’ imprisonment and upwards of a $10,000 fine. It’s a pretty serious situation.

Texas Nurses Association recently learned of the accusation that the two nurses – both TNA members – reported a physician at their hospital – a county hospital – to the Texas Medical Board because they had concern that the physician’s practice was below the acceptable standard of care. The nurses were soon thereafter terminated by their hospital employer. And, the physician had also filed a harassment complaint against them with the county sheriff’s department. The criminal charges according to a television news broadcast by KWES NewsWest 9 in Midland, Odessa, Big Spring, were because the nurses “sent patient files to the state medical board in an attempt to harm one of the hospital’s physicians.”

Because the two nurses, Vicki Galle, RN and Anne Mitchell, RN, worked for a county hospital – and included medical record numbers of the patients in their report (actually, no patient names were disclosed) – they were charged with the felony crime of misuse of official information. Even though the Texas Medical Board stated in a letter to Winkler County attorneys that disclosing of patient identification numbers is allowed under state and federal law, the nurses must still defend themselves against the criminal charge. And, they are without their jobs.

Retaliation?

While Texas Nurses Association is aware of other cases of nurses being retaliated against because they advocated for patients, this is the first case in Texas in which nurses have been criminally charged for acting as patient advocates. TNA stands on the belief that no nurse should be retaliated against – intimidated, coerced, threatened, harassed, demoted, written up or fired – for advocating for a patient.

“It is an absolute right,” states Clair Jordan, MSN, RN, executive director of Texas Nurses Association, “that has directed TNA for over 20 years to pass laws to protect nurses from such retaliation. This whole criminal case is just outrageous,” she said.

TNA Establishes Legal Defense Fund

To support the legal rights of these nurses in Winkler County – and the rights of every practicing nurse in Texas to advocate for patients – Texas Nurses Association has established the TNA Legal Defense Fund. The first $10,000 in donations to the fund will be used exclusively to assist the nurses in Winkler County with their legal defense. Texas Nurses Association will match every $1 contributed to the fund by individual nurses up to $5000. If funds are collected in excess of $10,000, it is TNA’s intent to use at least part of those excess funds to support nurses who are retaliated against because they advocated for their patients.

To make contributions to the TNA Legal Defense Fund, please use either the form below or visit texasnurses.org to make a secure, online contribution with a credit card. Please join with Texas Nurses Association in ensuring the right of nurses to advocate for patients without fear of retaliation by contributing to the TNA Legal Defense Fund.

Texas Nurses Association Establishes Legal Defense Fund

Join with TNA in ensuring the right of nurses to advocate for patients without fear of retaliation.

Yes, I am as appalled as Texas Nurses Association is at the criminal indictments of the two TNA member nurses in Winkler County, and want to join TNA in sending the message that their nursing colleagues are standing in support of them. Enclosed is my contribution for:

$15  $25  $50  $100  Other

Name __________________________________________
Address _______________________________________

Payment is by:  

_______ Check (made payable to TNA Legal Defense Fund) and mailed to TNA Legal Defense Fund, 7600 Burnet Road, Suite 440, Austin, TX 78757

_______ Credit Card (please provide the following information)

Card Type:  ____ Visa®  ____ MasterCard®  ____ American Express®

Card Number: __________________________________________

Name on Card: __________________________________________

Billing Address for Credit Card: __________________________

Card Expiration Date: __________

I acknowledge and agree that the first $10,000 collected for the TNA Legal Defense Fund including the $5000 matching funds contributed by Texas Nurses Association will be used to assist the nurses indicted in Winkler County, but that any additional funds may be used to support other nurses who are retaliated against because they advocated for patients.

Signature __________________________________________
Date __________

Contributions to the TNA Legal Defense Fund are also being accepted online via secure credit card payment using Visa®, MasterCard® or American Express®.
Nursing Champions of the 2009 Legislature

To pass, legislative bills need a majority yea vote of the 31-member Senate and 150-member House of Representatives. Only a fraction of the 7400-plus bills filed in the 2009 regular Texas legislative session were passed.

Passing a bill requires special effort by one or more individual legislators to shepherd it successfully through the process. Texas Nurses Association’s legislative successes in 2009 were possible because of the special efforts of several individual legislators who authored or sponsored nursing bills and amendments, advocated for nursing when the bills were debated, and supported the bills in committee. TNA refers to these legislators as “nursing champions” – legislators who go the extra mile to support nursing and ensure the success of nursing’s legislative initiatives. TNA and nursing’s legislative champions for the 2009 legislative session are:

Nursing Champions in the House

Rep. Donna Howard (D–Austin) was the House sponsor of the Safe Hospital Staffing Act (SB 476) which passed. She was also joint author of a House floor amendment to the appropriations bill that increased the funding for professional nursing education. She authored legislation (which did not pass) to extend to publicly-employed nurses the full protections from retaliation for engaging in protected patient advocacy activities enjoyed by privately-employed nurses. Rep. Howard holds a BSN and practiced nursing for a number of years in Austin.

Rep. Susan King (R–Abilene) was a joint sponsor in the House of the Safe Hospital Staffing Act (SB 476) which passed. As a member of the House Appropriations Committee, she worked to secure additional funding for nursing education and was a joint author of a House floor amendment to the appropriations bill that increased the funding for professional nursing education. Rep. King is an RN who practices in Abilene. She is a member of the House Committee on Public Health.

Rep. Jim McReynolds (D–Lufkin) authored HB 3961 (passed) making a number of nursing-supported amendments to the Nursing Practice Act (NPA) and was House sponsor for SB 1415 (passed) giving the Board of Nursing (BON) more options in addressing minor violations of the NPA and BON rules. Rep. McReynolds is a member of the House Committee on Public Health.

Rep. Lois Kolkhorst (R–Brenham) actively worked to secure more funding for professional nursing education and authored HB 4471 (passed) amending the Professional Nursing Shortage Reduction Program. She was joint author of a House floor amendment to the appropriations bill that increased the funding for professional nursing education. Rep. Kolkhorst chairs the House Committee on Public Health which is the House committee that considers almost all nursing and health-related legislation. She was also a member of the Senate Finance Committee and worked for increased funding to address the nursing shortage.

Rep. Wayne Christian (R–Center) authored a House bill (did not pass) which would have authorized Advanced Practice Nurses (APNs) to prescribe medications under the authority of their nursing license, and eliminated the requirement that a physician must delegate prescriptive authority to an APN.

Rep. Rob Orr (R–Burleson) authored a House bill (did not pass) which would have simplified how physicians delegate prescriptive authority to Advanced Practice Nurses (APNs) by replacing the current site-based model of delegation with a model based on a prescriptive authority agreement.

Rep. Garnet Coleman (D–Houston) sponsored SB 158 (passed by Senate but not House) which would have required school districts to notify parents if there was not a full-time school nurse at their child’s school. Rep. Coleman also authored legislation (did not pass) that would have required schools to have a school nurse. Rep. Coleman is a member of the House Committee on Public Health.

Nursing Champions in the Senate

Sen. Jane Nelson (R–Lewisville) was the Senate sponsor of the Safe Hospital Staffing Act (SB 476) which passed. She was the Senate sponsor for HB 3961 (passed) making a number of nursing-supported amendments to the Nursing Practice Act (NPA). Sen. Nelson chairs the Senate Committee on Health and Human Services which is the Senate committee that considers almost all nursing and health-related legislation. She was also a member of the Senate Finance Committee and worked for increased funding to address the nursing shortage.

Sen. Glenn Hegar (R–Katy) was the author of SB 1415 (passed) giving the Board of Nursing (BON) more options in addressing minor violations of the Nursing Practice Act (NPA) and BON rules. He also authored a Senate bill (did not pass) which would have simplified how physicians delegate prescriptive authority to Advanced Practice Nurses (APNs) by replacing the current site-based model of delegation with a model based on a prescriptive authority agreement.

Sen. Rodney Ellis (D–Houston) authored SB 158 (passed by Senate but not House) which would have required school districts to notify parents if there was not a full-time school nurse at their child’s school.★
Negotiations with Surgical Technologists Results in Passage of Legislation

By Denise Jackson, MSN, RN, CNS, CRNFA

Each legislative session, legislation is initiated by other groups that, while perhaps is not the intent, does have the potential to affect nursing negatively. I experienced that firsthand this session with legislation (HB 643) initiated by surgical technologists. As originally filed, HB 643: 1) broadly defined “surgical technology” in a way that could be expanded to allow tasks beyond what nursing considered to be within a surgical technologist’s range of function; 2) could have possibly been interpreted in the future as precluding RNs and LVNs from functioning in the “scrub role;” and 3) did not reflect current RN supervision of the surgical technologist; and 4) repealed current law which requires the circulator to be a registered nurse.

The Texas Nurses Association (TNA) and Texas Council of periOperative Registered Nurses (TCORN) joined together to articulate nursing’s concerns to the bill author, Representative John Zerwas. Rep. Zerwas is an anesthesiologist and is very familiar with the operating room environment. He expressed his concern that the surgical technologist was the only member of the surgical team not regulated and his belief that patient safety would be promoted by surgical technologists. There were also discussions regarding the difference and similarities of the role of the scrub person as performed by a surgical technologist or by a registered nurse. We were unable to reach consensus regarding supervision and delegation but did find common ground on several other aspects of the bill. HB 643 was filed early in the session but since stakeholder agreement had not been reached, Rep. Zerwas and his staff held several individual and group stakeholders’ meetings. On several occasion, Jim Willmann. TCORN also had a committee of key members who would provide feedback on proposed changes. Although agreement was ultimately reached on a bill that nursing could support, achieving that agreement was not easy. During Summer 2008, representatives of TCORN and TNA met with the surgical technologist representatives and discussed the current RN Circulator supervision and delegation of the surgical technologist. There were also discussions regarding the difference and similarities of the role of the scrub person as performed by a surgical technologist or by a registered nurse. We were unable to reach consensus regarding supervision and delegation but did find common ground on several other aspects of the bill. HB 643 was filed early in the session but since stakeholder agreement had not been reached, Rep. Zerwas and his staff held several individual and group stakeholders’ meetings. On several occasion, Jim and I would spend a weekend drafting proposed language which I would immediately share with TCORN members so that a proposal could be shared on Monday with Rep. Zerwas’ staff or other stakeholders.

The final outcome of the meetings was a bill that nursing and all the other stakeholders could support. Once that agreement was reached, the bill passed the House and Senate without opposition. HB 643 mandates that hospitals and ambulatory surgical centers employ only surgical technologists who have met certain education and certification requirements. Certification may be through the National Board of Surgical Technology and Surgical Assisting (NBSTSA) or the National Center for Competency Testing (NCCT). Surgical technologists currently employed are grandfathered in. As passed, HB 643 addresses the concerns nursing had about the bill by: 1) precisely defining surgical technology which limits to a definitive list the tasks and functions that may be performed by surgical technologists; 2) specifically exempting both RNs and LVNs to ensure the scrub role remains in their scope of practice; 3) stating clearly that HB 643 makes no change in how surgical technologists are currently supervised or their relationship to the circulating RN; and 4) removing the RN Circulator repealer clause.

Nursing was pleased with the outcome on HB 643. Rep. Zerwas’ commitment to keeping everyone at the table and his openness to hearing everyone’s concerns made it possible to eventually reach agreement. The best outcome is that patients will be the ultimate beneficiaries of raising the standards in OR.

About the Author:

Denise Jackson, MSN, RN, CNS, CRNFA, is a Clinical Nurse Specialist and a Certified RN First Assistant who practices in San Angelo. She just completed her term as the legislative committee chair for the Texas Council of periOperative RNs (TCORN), the Texas State Legislative Coordinator for the Association of periOperative Nurses (AORN), and the TCORN representative to the Texas Nursing Legislative Agenda Coalition. Denise is a member of TNA District 16. She was also actively involved in previous legislative sessions with legislation addressing RN First Assistant reimbursement, and the RN circulator role.
The nurses in Galveston have been through a lot this last year. Thanks to Hurricane Ike, the most intense storm of the 2008 hurricane season and the third most destructive hurricane to make U.S. landfall, many of Galveston’s nurses lost their jobs, not to mention the island life they’d known including their homes.

September 13 will mark one year’s time since Hurricane Ike devastated Galveston Island. Aside from the 112 U.S. fatalities (195 total fatalities) and the $24 billion of estimated damages, 2409 employees lost their positions last November at The University of Texas Medical Branch (UTMB), a storm ravaged facility. This included approximately 1200 clinical employees who lost their jobs in a single day.

The ones who remained have been a huge part of getting UTMB back to its pre-Ike bed capacity. In early October 2008, UTMB employees returned to work. Women’s services resumed operations on October 13, 2008, and by year’s end, 1192 infants had been safely delivered. John Sealy Hospital re-opened January 5, 2009 with limited bed capacity, and plans are in place to re-open the ER late this summer. The nurses who remained have been working in different geographic units, with different patient populations than they did before Ike and generally, in completely different work groups than before the storm. UTMB is also hiring significant numbers of new nurses to meet the demands as additional beds are opened.

“While UTMB nurses have been ramping up patient care efforts,” explained Ellarene Duis Sanders, PhD, RN, CNAA, BC, “they’re still going home to disarray and destruction. It’s tough,” she emphasized. Besides being UTMB’s Magnet® project director and facilitator of shared governance, Sanders is also president of Texas Nurses Association District 6 which is basically Galveston Island.

“That’s why for all the nurses at UTMB – both TNA members and not – the TNA District 6 has been making plans to host a conference in Galveston – some kind of special event – to recognize the exceptional efforts of our nurses and to offer them healing and stress relief tools,” Sanders explained. The event is planned for sometime in the Fall of 2009.

TNA District 6 has also been receiving contributions for this special event from nurses outside of the Galveston area. A silent auction was held in April by the Texas Nurses Foundation with proceeds going to benefit the nurses impacted by Hurricane Ike, and to support this year’s efforts of Ready Texas Nurses emergency response system that activates volunteer nurses in times of crisis and disaster (see sidebar). Donations also came from other TNA Districts across Texas, and individual donors.

And other good news: UTMB will have about $1.4 billion to restore and expand. According to UTMB, most of that money was approved by the 81st Texas Legislature during the regular session, plus $450 million from FEMA, $130 million from insurance, $200 million from the Sealy and Smith Foundation, and $50 million from the Social Service Block Grant Funds.
Cancer Surivorship Crosses Nursing Specialties

by Joni Watson, MSN, RN, OCN. Program Director, Nurse Oncology Education Program

Cancer is now the leading cause of death for people under age 85 and the leading disease-specific cause of death for young adults ages 15-29 (ACS, 2009; Bleyer, et al., 2006; Jemel, et al., 2006). Due to advances in prevention, detection and treatment, the number of Texas cancer survivors is increasing (TCC, 2005). With more than 1.4 million new cancer cases expected in 2009, a 66 percent overall five-year survival rate for all cancers, and nearly 12 million Americans living with a history of cancer, nurses in all fields of practice must be aware of the specific issues cancer survivors face every day (TCC, 2005; ACS, 2009). Nurses have the opportunity to impact cancer survivors no matter the nursing specialty.

Survivors are those individuals living with cancer and those who are affected by the diagnosis, including family members, friends and caregivers. Cancer survivorship proceeds along a continuum — from the moment of diagnosis through and beyond treatment to remissions, recurrences, cure and the final stages of life (NCCN, 2008). Each person’s survivorship experience is different, and effects of cancer are classified as physical, emotional or practical.

Physical

There are numerous system-specific effects of cancer, which depend on the location of the cancer and the type of treatments used; every system is susceptible. Functional changes such as lymphedema, neuropathy, fatigue, among many other effects, and cosmetic changes including ostomies, alopecia, scars, and amputations can dramatically change survivors’ quality of life.

Survivors experience a variety of effects as a result of treatment. Concern about the side effects of chemotherapy and radiation therapy often cause survivors to fear the worst, and fear and anxiety can even complicate treatment. Acute effects such as pain, fatigue, radiation burns, dyspnea and nausea, occur after the onset of illness or treatment and last for a brief period. Long-term effects such as pain, fatigue, peripheral neuropathy, lymphedema and insomnia, are persistent or chronic problems that may develop during or as a result of treatment and may persist for months to years. Late effects such as pulmonary fibrosis, infertility, and secondary malignancies are usually absent or subclinical at the end of therapy and then become apparent months to years after completion of treatment.

Pain is often present throughout the survivorship continuum. "Nearly 90% of all patients experience cancer-related pain during and/or after treatment" (NAS, 2007). Pain can be caused by the cancer itself, such as tumors pressing on surrounding tissues and organs, or by the cancer treatment. Effects from cancer treatment can range from mild to life-threatening, and may be multi-factoral, putting survivors at risk (Rowland, 2005).

Emotional

Emotional concerns are easily overlooked while focusing on physical needs. Cancer, just like any other life-threatening event, is a major occurrence within a family. There is no standard emotional response to cancer survivorship. Rather, there are a myriad of emotions that can arise during the survivorship continuum from fear and anxiety to depression and even ambivalence about care. On the other hand, survivors can also face numerous positive emotions such as satisfaction with deepening relationships, spiritual awakening, and finding strength within. Many survivors describe these conflicting emotions as an "emotional rollercoaster" — up one day and down the next.

Cancer also has many effects on a patient’s and a caregiver’s identity. The effects extend well into the family and social circles. A partner who has been a life-mate or lover may take on a more parental role in caring for the patient. Adjusting to physical and psychosocial barriers is something the survivor — as well as the survivor’s family — must confront. Survivors cope in a variety of healthy and unhealthy ways. Unhealthy coping strategies include blaming, withdrawing into isolation, reducing tension with excessive drugs, drinking or danger. Appropriate coping strategies are effective and healthy, and should be identified for both the survivor and the family.

Life threatening illnesses tend to cause evaluation and reflection of life and purpose. Life priorities and values usually change after critical evaluation and a search for meaning. Spiritual beliefs and cultural values influence how individuals view life, death and survivorship. When spiritual issues are discussed with openness and respect, nurses can help ensure a positive quality of life. There is usually a deepening sense of spirituality along the cancer survivorship continuum, and it’s important to know that may or may not include organized religion.

Practical

One of the most frequently overlooked areas of concern within cancer survivorship is the myriad of practical issues surrounding a life-threatening diagnosis. Cancer affects everyone in the family and can cause numerous role changes. A family member not used to being the breadwinner or the caregiver can burn out easily. Families must also be included in education and support services. In addition to relationship stresses, financial concerns impact cancer survivors and their families. Because cancer treatments can be very expensive due to recurring multi-drug therapies, survivors’ finances are often impacted to the point of bankruptcy many times.

Many cancer survivors remain in the workforce, even during treatment, and also face challenges with work including employability,

Cancer Survivorship continued on page 16
preconceived notions about the limitations of cancer, securing or maintaining health and life insurance due to qualifications and/or cost, avoidance by coworkers, job lock (being stuck in a job you don’t want any more), and even job termination. Coupled with general malaise and nausea and/or mounting debt, life can be overwhelming (Cabe & Springer, 2008).

Numerous federal and state laws insure protection against discrimination including the Federal Rehabilitation Act of 1973, COBRA, ADA, FMLA, HIPPA and GINA, or the Genetic Information Nondiscriminatory Act, passed in 2008 to protect against discrimination based on genetic information in regards to health insurance and employment.

Despite all of our increased awareness of cancer, social stigma related to certain cancers does still exist. For example, lung cancer, which is typically a “smoker’s disease,” has a lot of stigma, even for those with the disease who have never smoked. Cancer stigma may be compounded in special populations including rural survivors, young adults ages 15-29 who are expected to be “healthy,” LGBT (lesbian, gay, bisexual and transgendered) survivors, and survivors from other countries.

Although at least one-third of the cancer population experiences some variety of distress in any of these three areas (physical, emotional and practical), only about 10% receive any psychosocial therapy (Vachon, 2006). Nurses in all fields of practice can assess for physical, emotional and practical issues and distress across the nursing spectrum and greatly impact survivors and their families wherever they are in the survivorship continuum.

With numerous holistic interventions, nurses can be the catalyst to help survivors during their cancer journey. Nurses in all fields of practice can increase survivors’ quality of life through education, active listening, ensuring good pain management and palliation of symptoms, and working with the survivor and family to develop and maintain an interdisciplinary, evidence-based wellness plan, also known as a survivorship care plan (Haylock, et al., 2007).

In 2005, the Institute of Medicine published Cancer Patient to Cancer Survivor: Lost in Transition. Of the report’s ten recommendations, the one that has received the most attention from professional organizations is the call for the creation of a survivorship care plan for any patient who completes initial treatment. Survivorship care plans, such as the Prescription for Living and the LIVESTRONG Care Plan, are survivorship care plans, such as the Prescription for Living and the LIVESTRONG Care Plan, are available from professional organizations is the call for the creation of a survivorship care plan for any patient who completes initial treatment. Survivorship care plans, such as the Prescription for Living and the LIVESTRONG Care Plan, are summaries of the treatment and care received. They include descriptive disease characteristics, recommended follow up care, and available resources. Nurses in all fields of practice will see survivorship care plans more frequently as they are becoming standardized and widely available.

Cancer survivors are becoming an increasingly large part of the general population. Nurses in all fields of practice can impact survivors’ physical, emotional and practical needs throughout the survivorship continuum of care and must be aware of survivors’ unique needs. For more information and education on cancer and survivorship, please visit the Lance Armstrong Foundation at www.livestrong.org and the Nurse Oncology Education Program (NOEP) at www.noetx.org. NOEP is a project of the Texas Nurses Association/Foundation funded by the Cancer Prevention and Research Institute of Texas.

References


CASA Volunteers Give Help and Hope to Children in Need

by Melanie Grammar, RN, BSN and Court Appointed Special Advocate Volunteer

As a registered nurse, my schedule is already pretty busy providing care to individuals who are sick and support to their families. Therefore, my free time is important to me. That’s why I choose to spend it as a CASA (Court Appointed Special Advocate) volunteer. As a CASA volunteer, I can use some of my free time – and my skills and knowledge as a nurse – to provide help and hope to abused and neglected children.

My first case showed me how my experience as a nurse could compliment my work for children through CASA. Sarah (not her real name) was a young girl in foster care who had cerebral palsy with severe spasticity, mental retardation, scoliosis of her spine, and asthma. She could not speak so understanding her needs could be tough to almost impossible. When I went to visit her for the first time in her foster home, I got a feeling that something was not right. It was here that my nursing training kicked in.

As nurses, we are taught to use our critical thinking, and then dig for the answers to our questions. When I asked why Sarah, who was 8 years old, only weighed 37 pounds, Sarah’s foster mom became very defensive. The foster mom said she had a feeding tube problem and that she took Sarah to the children’s hospital for all her appointments, which were many.

After reviewing her medical records and speaking to her doctors and the school nurse, it appeared Sarah was being starved. I also found out that Sarah had been missing appointments and had not been receiving the care which CASA and the courts were being told she was obtaining. Sarah was in trouble and needed quick intervention to save her. I was willing to go do whatever needed to be done.

By making phone calls and follow up visits, I was able to update all the various groups on Sarah’s case and go before the judge to explain the critical need of removing Sarah from her situation. The judge did order an emergency removal from the foster home and Sarah was then placed in a loving home. Soon she was healthy and had the special equipment she needed to help her movements. She eventually gained 30 pounds, putting her at a healthy weight for her small frame.

After the court hearing, I felt that with my help this small, helpless little girl had been given a chance at life in a safe, loving home. It was then that I knew my being a CASA volunteer really can make a huge difference in the life of a child, and that my experience and training as an RN is a great resource for helping these children survive. With my flexible schedule, I can do my important work as a nurse, and then have the time to review records and monitor a child’s progress, visit the child and their families, participate in court hearings and important meetings, and help guide the child through the foster care system and into a safe, permanent home.

To learn more about CASA and how you can help a child, visit www.becomeacasa.org.

CASA Volunteers Give Help and Hope to Children in Need

Governor Appoints New BON Members

Texas Gov. Rick Perry made appointments late in May to the Texas Board of Nursing. Three of the new appointments to the 13-member BON are nurses. The BON ensures licensed nurses in Texas meet the necessary requirements to practice safely.

New appointments are:

- Tamara Cowen, MN, RN, assistant vice president, Patient Safety Solutions for the Valley Baptist Health System, Harlingen. Represents RN practice.
- Josefina Lujan, PhD, RN, regional dean, Texas Tech University Health Sciences Center Anita Thigpen Penny School of Nursing in El Paso. Represents BSN programs of nursing.
- Mary Jane Salgado, MEd, economic developer of the Kickapoo Traditional Tribe of Texas, and a licensed real estate agent, Eagle Pass. Represents consumers.

The new appointees join eight other BON members who represent APN education, LVN education, ADN programs, BSN programs, RN practice, LVN practice, and consumers. All terms of service for the new appointments expire January 31, 2015.

Texas Nursing Voice • Page 17 July, August, September 2009

CASA Volunteers Give Help and Hope to Children in Need

by Melanie Grammar, RN, BSN and Court Appointed Special Advocate Volunteer

As a registered nurse, my schedule is already pretty busy providing care to individuals who are sick and support to their families. Therefore, my free time is important to me. That’s why I choose to spend it as a CASA (Court Appointed Special Advocate) volunteer. As a CASA volunteer, I can use some of my free time – and my skills and knowledge as a nurse – to provide help and hope to abused and neglected children.

My first case showed me how my experience as a nurse could compliment my work for children through CASA. Sarah (not her real name) was a young girl in foster care who had cerebral palsy with severe spasticity, mental retardation, scoliosis of her spine, and asthma. She could not speak so understanding her needs could be tough to almost impossible. When I went to visit her for the first time in her foster home, I got a feeling that something was not right. It was here that my nursing training kicked in.

As nurses, we are taught to use our critical thinking, and then dig for the answers to our questions. When I asked why Sarah, who was 8 years old, only weighed 37 pounds, Sarah’s foster mom became very defensive. The foster mom said she had a feeding tube problem and that she took Sarah to the children’s hospital for all her appointments, which were many.

After reviewing her medical records and speaking to her doctors and the school nurse, it appeared Sarah was being starved. I also found out that Sarah had been missing appointments and had not been receiving the care which CASA and the courts were being told she was obtaining. Sarah was in trouble and needed quick intervention to save her. I was willing to go do whatever needed to be done.

By making phone calls and follow up visits, I was able to update all the various groups on Sarah’s case and go before the judge to explain the critical need of removing Sarah from her situation. The judge did order an emergency removal from the foster home and Sarah was then placed in a loving home. Soon she was healthy and had the special equipment she needed to help her movements. She eventually gained 30 pounds, putting her at a healthy weight for her small frame.

After the court hearing, I felt that with my help this small, helpless little girl had been given a chance at life in a safe, loving home. It was then that I knew my being a CASA volunteer really can make a huge difference in the life of a child, and that my experience and training as an RN is a great resource for helping these children survive. With my flexible schedule, I can do my important work as a nurse, and then have the time to review records and monitor a child’s progress, visit the child and their families, participate in court hearings and important meetings, and help guide the child through the foster care system and into a safe, permanent home.

To learn more about CASA and how you can help a child, visit www.becomeacasa.org.

CASA Volunteers Give Help and Hope to Children in Need

Governor Appoints New BON Members

Texas Gov. Rick Perry made appointments late in May to the Texas Board of Nursing. Three of the new appointments to the 13-member BON are nurses. The BON ensures licensed nurses in Texas meet the necessary requirements to practice safely.

New appointments are:

- Tamara Cowen, MN, RN, assistant vice president, Patient Safety Solutions for the Valley Baptist Health System, Harlingen. Represents RN practice.
- Josefina Lujan, PhD, RN, regional dean, Texas Tech University Health Sciences Center Anita Thigpen Penny School of Nursing in El Paso. Represents BSN programs of nursing.
- Mary Jane Salgado, MEd, economic developer of the Kickapoo Traditional Tribe of Texas, and a licensed real estate agent, Eagle Pass. Represents consumers.

The new appointees join eight other BON members who represent APN education, LVN education, ADN programs, BSN programs, RN practice, LVN practice, and consumers. All terms of service for the new appointments expire January 31, 2015.

Texas Nursing Voice • Page 17 July, August, September 2009

CASA Volunteers Give Help and Hope to Children in Need

by Melanie Grammar, RN, BSN and Court Appointed Special Advocate Volunteer

As a registered nurse, my schedule is already pretty busy providing care to individuals who are sick and support to their families. Therefore, my free time is important to me. That’s why I choose to spend it as a CASA (Court Appointed Special Advocate) volunteer. As a CASA volunteer, I can use some of my free time – and my skills and knowledge as a nurse – to provide help and hope to abused and neglected children.

My first case showed me how my experience as a nurse could compliment my work for children through CASA. Sarah (not her real name) was a young girl in foster care who had cerebral palsy with severe spasticity, mental retardation, scoliosis of her spine, and asthma. She could not speak so understanding her needs could be tough to almost impossible. When I went to visit her for the first time in her foster home, I got a feeling that something was not right. It was here that my nursing training kicked in.

As nurses, we are taught to use our critical thinking, and then dig for the answers to our questions. When I asked why Sarah, who was 8 years old, only weighed 37 pounds, Sarah’s foster mom became very defensive. The foster mom said she had a feeding tube problem and that she took Sarah to the children’s hospital for all her appointments, which were many.

After reviewing her medical records and speaking to her doctors and the school nurse, it appeared Sarah was being starved. I also found out that Sarah had been missing appointments and had not been receiving the care which CASA and the courts were being told she was obtaining. Sarah was in trouble and needed quick intervention to save her. I was willing to go do whatever needed to be done.

By making phone calls and follow up visits, I was able to update all the various groups on Sarah’s case and go before the judge to explain the critical need of removing Sarah from her situation. The judge did order an emergency removal from the foster home and Sarah was then placed in a loving home. Soon she was healthy and had the special equipment she needed to help her movements. She eventually gained 30 pounds, putting her at a healthy weight for her small frame.

After the court hearing, I felt that with my help this small, helpless little girl had been given a chance at life in a safe, loving home. It was then that I knew my being a CASA volunteer really can make a huge difference in the life of a child, and that my experience and training as an RN is a great resource for helping these children survive. With my flexible schedule, I can do my important work as a nurse, and then have the time to review records and monitor a child’s progress, visit the child and their families, participate in court hearings and important meetings, and help guide the child through the foster care system and into a safe, permanent home.

To learn more about CASA and how you can help a child, visit www.becomeacasa.org.
On September 24 and 25, Texas Nurses Association will host its 9th Annual Nursing Leadership Conference. As is custom, noted nursing and health care researchers, policy stakeholders, and legislative experts will offer provocative perspective on issues destined to challenge today’s health care environment and its practitioners.

FEATURED SPEAKERS

Mark B. McClellan, MPA, MD, PhD, senior fellow and director of the Engelberg Center for Health Care Reform at the Brookings Institution; Leonard D. Schaeffer Chair in Health Policy Studies.

With health care reform a top-of-mind concern of most Americans, the 9th Annual Nursing Leadership Conference has the privilege of presenting Mark B. McClellan of the distinguished Brookings Institution of Washington, D.C., one of America’s most influential and trusted think tanks. As director of Brookings’ Engelberg Center for Health Care Reform, McClellan leads the Center’s efforts to provide practical solutions for achieving innovative, quality and affordable health care, with a particular emphasis on identifying local, state and national opportunities. Dr. McClellan will address Conference attendees on what health care reform means for nursing.

Jack Needleman, PhD, FAAN, associate professor, Department of Health Services, UCLA School of Public Health.

Anyone who’s read any noteworthy research in the last decade on quality and access to care has already met Dr. Jack Needleman. He is renowned for his research on the impact of nurse staffing and nurses working conditions on patient outcomes in hospitals and the business case for increasing nurse staffing. He continues research in this area and is currently leading the team evaluating Transforming Care at the Bedside, a Robert Wood Johnson Foundation® initiative that’s intended to improve the quality, safety, and efficiency of hospital med-surg units by engaging staff and managers in process improvement. At this year’s Nursing Leadership Conference, attendees will have the distinct privilege of engaging with Dr. Needleman.

Debora Simmons, MSN, RN, CCRN, CCNS, research scientist and associate director of the Patient Safety Education Project, Texas A&M University Health Science Center Rural and Health Institute.

With an extensive background in patient safety, complex patient care systems, and the work environment of health care, Simmons will share with Nursing Leadership Conference attendees the current patient safety research that impacts nursing practice and the ability of providers to practice safely.

K. Lynn Wieck, PhD, RN, FAAN, Jacqueline M. Braithwaite
Professor at The University of Texas at Tyler in the online PhD nursing program; chief executive officer of Management Solutions for Healthcare, a nurse consultancy for health policy and workforce issues; and researcher in nursing workforce issues with a particular expertise in intergenerational harmony.

Dr. Lynn Wieck will offer Nursing Leadership Conference attendees insight into another intriguing component of health care reform—a multi-generational workforce of four distinct generations who have inherent differences in their behavior, technology comfort, communications styles and approach to work. Key to achieving any health care reform is for employers to recognize and address the imminent organizational challenges they will soon face and begin now to uncover insight, understanding and a meeting of the generational minds.

NURSING IN TEXAS PERSPECTIVE

When the 81st Texas Legislature ended its regular session this past June, nursing in Texas had gained a Safe Hospital Staffing Act, changes to the Nursing Practice Act, and a new total from the legislature—now over $100 million—to address the nursing shortage in Texas. As has become a must-include in TNA’s Annual Nursing Leadership Conference, a team of Texas experts—Clair Jordan, MSN, RN, executive director, Texas Nurses Association; James H. Wilmann, JD, Texas Nurses Association; Elizabeth Sjoberg, JD, RN, Texas Hospital Association; and Kathy Thomas, MN, RN, executive director, Texas Board of Nursing—will provide attendees with the an update on the new regulations, legislation and policies that will now govern nursing practice and the rights of the practicing nurse.

REGISTRATION DETAILS

Registration for the 9th Annual Nursing Leadership Conference is available online at texansnurse.org or by mailing or faxing the registration form provided here. Both checks (made payable to Texas Nurses Association) and credit cards are accepted. Registration confirmation will be provided.

Registration fees and Group discounts: Please see details next page on registration form.

HOTEL ACCOMMODATIONS

Host hotel: Omni Austin Hotel Southpark, 4140 Governor’s Row, Austin. Toll-free reservations by phone: 800.THE-OMNI; online reservations at texansnurse.org OR omnihotels.com.

Room rate: $130 plus applicable taxes per night for single/double room. Hotel reservation deadline is September 2 for reserving the special Nursing Leadership Conference room rate.

ADDITIONAL INFORMATION/QUESTIONS

Additional information is available from Texas Nurses Association, 800.862.2022 ext. 3 or via e-mail to cne@texansnurse.org.
REGISTRATION FORM: 2009 TNA NURSING LEADERSHIP CONFERENCE, SEPTEMBER 24-25

FILL IN THIS FORM, PRINT AND FAX IT TO TEXAS NURSES ASSOCIATION AT 512-323-5379, OR MAIL FORM TO: Texas Nurses Association, 7800 Burnet Road, Suite 440, Austin, TX 78757-1292, ATTN: TNA Nursing Leadership Conference.

Online registration and payment is also available at texasonurses.org - Events. Seating is limited. Prompt registration is advised and encouraged. Onsite registration is subject to space availability. Registration is NOT COMPLETE until payment is received by TNA.

Check in begins at 7:30 a.m. on September 24. Conference ends at 3:45 p.m. on September 25.

Registrations include both breakfast and lunch each day. REGISTRATION CONFIRMATION WILL BE SENT.

Additional information: one@texasnurses.org or by phone to 512-452-0645 x125.

CANCELLATION POLICY
Cancellations will be honored if a written request is received at Texas Nurses Association at least one week prior to the activity. A $25 processing fee will be deducted from all refunds. Send written request to one@texasnurses.org or fax to 512-323-5379.

The conference planning committee reserves the right to cancel this activity or substitute faculty in the event of unforeseen or extenuating circumstances.

REGISTRATION PER ATTENDEE:

| Before September 10, 2009 | Member: $375.00 | Non-Member: $475.00 |
| After September 10, 2009 | Member: $400.00 | Non-Member: $500.00 |

There is NO student discount for this conference. GROUP DISCOUNT: Groups of 5 or more registrants from the same facility are eligible for a 10% discount per registrant. To receive the discount, all of the group’s registrations must be received together using the printed registration form (one form per registrant) and paid with one payment — either check or credit card.

After September 22, 2009 – Phone 1-800-862-2022 ext. 125 for availability

TO REGISTER: FILL IN THE INFORMATION BELOW - ONE FORM PER REGISTRANT

- I am a TNA/ANA Tri-Level Member or TNA Direct Member
- I am a Non-Member
- I am employed by a Magnet® designated hospital
- I am employed by a Nurse-Friendly®/Pathway to Excellence® designated hospital
- I am interested in receiving information about TNA membership
- Send me information about future programs/offers via e-mail
- You may share my e-mail address with 2009 Nursing Leadership Conference exhibitors.

ALL FIELDS ARE REQUIRED FOR FULL REGISTRATION

- First name ___________________________
- Last name ___________________________
- Preferred badge name ___________________________
- Credentials ___________________________
- Home address ___________________________
- City ___________________________ State __ Zip _______  
- Employer ___________________________
- Preferred Phone ___________________________ Best time to call _______
- E-mail ___________________________  
- [If unemployed/unaffiliated please indicate in this field]
- Month and Date of Birth (MA/DD) ___________________________ (used for identification purposes only)

PAYMENT INFORMATION

EITHER a check is enclosed made payable to Texas Nurses Association in the amount of: $ _______

OR charge amount: $ _______ to this credit card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card ___________________________

Card Number _______ _______ _______ _______
Exp. Date _______ _______  

Credit card billing address if different from home address:

Address ___________________________

City ___________________________ State ___ Zip _______  

Signature ___________________________ Date _______

The Texas Nurses Association Foundation Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
Texas Nurses Association
CAREER CENTER
Connecting Professionals with Industry Leaders

job seeker
› Advance Your Career
› Post your Resume Anonymously
› Search Through Premier Job Postings
› Receive Job Alerts

employer
› Hire qualified job seekers
› Save time and money
› Post multiple positions
› Receive resume alerts

For more information, visit us online at www.texasnurses.org
selecting YOUR MEMBERSHIP

When joining Texas Nurses Association, you can choose from two membership options:

- **TNA Tri-Level Membership** that includes a state membership in Texas Nurses Association (TNA), national membership in American Nurses Association (ANA), and a more local District membership.
- **TNA Direct Membership** that is state wide Texas only.

**TNA TRI-LEVEL MEMBERSHIP**

Tri-Level Membership in ANA/ANA/District gives you the opportunity to influence nursing at every level—national, state, and local. TNA Tri-Level members receive full voting privileges; opportunities to grow and connect beyond the workplace through service on committees, task forces and coalitions; unique pathways to professional development; a network of like-minded colleagues, and member discounts on a variety of conferences/workshops, publications and resources, goods and services, as well as ANCC certification. Dues in TNA Tri-Level Membership are determined by your TNA District, the Type of membership that best describes you (i.e., Full-time employed, Part-time student, retired, etc.), and preferred method of dues payment. See Steps to Tri-Level Membership below.

**APPLICATION FOR MEMBERSHIP**

- **TNA Tri-Level and TNA Direct** - Fill out the required information and mail and return to: Texas Nurses Association, 7600 Burnet Road, Suite 440, Austin TX 78757-2202 or FAX with credit card information. FAX: 512.452.0644 or PHONE: 512.452.2822 or 512.452.0845

**MEMBERSHIP DUES viele**

<table>
<thead>
<tr>
<th>TRA LEVEL</th>
<th>FULL DUES</th>
<th>REDUCED DUES</th>
<th>S-SPECIAL DUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>Single</td>
<td>Single</td>
<td>Single</td>
</tr>
<tr>
<td>$399.00</td>
<td>$325.00</td>
<td>$250.00</td>
<td>$170.00</td>
</tr>
<tr>
<td>$299.00</td>
<td>$240.00</td>
<td>$175.00</td>
<td>$115.00</td>
</tr>
<tr>
<td>$249.00</td>
<td>$200.00</td>
<td>$150.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>$199.00</td>
<td>$155.00</td>
<td>$120.00</td>
<td>$75.00</td>
</tr>
<tr>
<td>$149.00</td>
<td>$115.00</td>
<td>$90.00</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

**MEMBERSHIP ELIGIBILITY**

To be eligible for TNA Tri-Level or TNA Direct membership, you must have been granted a license to practice as a registered nurse in a state, territory, possession or District of Columbia of the United States, and not have your license under suspension or revocation at any time.

**PAYMENT METHOD**

1. **Annually** - in a single, annual payment by check or credit card
2. **Bi-monthly** - by credit card draft or through the Direct Electronic Drafts Payment Plan (DEPP) where dues are automatically paid from your checking account. See “Select Payment Method” in Application for Membership.

**SELECT A PAYMENT METHOD FOR TEXAS NURSES ASSOCIATION MEMBERSHIP**

Indicate below your preferred method of payment:

- **Annual payment by check** (Please write in or apply online at Texas Nurses Association)
- **Direct Draft** (Please provide your bank information and direct deposit information)
- **Direct Electronic Draft Payment Plan (DEPP)**

**SELECT ONE MEMBERSHIP OPTION BELOW**

- **TNA DIRECT**

**REQUISITED INFORMATION FOR PAYMENT BY CREDIT CARD**

- **Charge to my:**
  - [ ] Visa
  - [ ] MasterCard
  - [ ] American Express
  - [ ] Discover
- **Credit card**
  - [ ] Debit Card
  - [ ] Credit Card
  - [ ] American Express
  - [ ] MasterCard
  - [ ] Visa
  - [ ] Discover
  - [ ] Other
- **Credit card information**
  - Name on card:
  - Card number:
  - Expiration date:
  - Security code:
- **EPPD AUTHORIZATION**

To provide a record of the payment, enter your TNA Tri-Level membership ID (incl. member ID and TNA/TNA Tri-Level membership ID) below or make sure your DEPP account is updated with your membership ID. Full payment must be received within 10 business days of the enrollment date. Unless otherwise requested in writing by the member, membership fees are nonrefundable after the enrollment date. If your membership payment is not received within the specified time frame, your membership will be canceled. Your membership ID number will not be disclosed to any third party for any reason.

To be completed by TNA:
- **Date:**
- **Signature:**
- **Approval:**

For faster results, go online to TXSNURSES.ORG > JOIN!