Complex challenges rarely have easy solutions. One such challenge is nurse staffing. The complexities stem from a variety of factors which include:

- type of patients being cared for
- setting and physical layout of the space in which the care is being delivered
- physiological complexity of the disease process and how it comprises physical activities for the patient
- number, competence and skill level of the caregivers
- availability of supportive staff roles, equipment and assistive devices

The nursing resources from various stakeholder groups such as ANA, Robert Wood Johnson, and others consistently point to key studies that make strong links between nurse staffing, patient safety and quality patient outcomes. This area of nursing research is growing rapidly, as it is a relatively new field of research on nurses and fatigue. These findings help define the importance of nurses in healthcare delivery, and the importance of having appropriate staffing levels to provide the required care. It also gives nurses the resources to make their own decisions about accepting overtime and other assignments where staffing may be an issue. We have included some helpful guidelines for you in this issue of the VNT.

(continued on page 2)
Over the last several years, states across the country have approached the problem of patient safety and quality care in different ways. One approach has been to mandate specific minimum nurse to patient ratios. Another approach is to mandate the development and implementation of nurse staffing plans, usually requiring appropriate input from the direct care RNs. A third approach requires institutions to publicly post nurse-to-patient ratios in an effort to increase public awareness of staffing levels, but not mandating the ratios or staffing levels. Some states have used top-patient ratios in an effort to increase public nurse staffing plans, usually requiring appropriate mandate the development and implementation of safety and quality care in different ways. One approach has been to mandate specific minimum numbers of registered nurses on each shift and in each unit of an institution to appropriate patient care. ANA's perspective is that this approach recognizes nurses as professionals and empowers them with the appropriate decision-making role in the care they provide.

VNA has posted staffing resources at www.virginianurse.com in a section of the website under workforce advocacy. There is also an Assignment despite Objection (ADO) form there for your use and guidelines provided in VNA's Workplace Advocacy Guide for Nurses publication. This guide was developed specifically for nurses practicing in Virginia. We encourage you to explore these resources, and give us feedback as to the kinds of tools you need to help you address the staffing challenge in your daily workplace.

As I travel the state, speaking with different nursing groups, I often ask what issues concern them the most, and the majority response, by far, is the nursing shortage and its impact on safe staffing levels. Perhaps the most valuable contribution that VNA makes toward safe staffing is the work done to advocate for solutions to the nursing shortage in Virginia. VNA has developed partnerships with key stakeholder organizations such as the Virginia Hospital and Healthcare Association (VHHIA) and the Virginia Organization of Nurse Executives (VONE), to assure that we share information and work together to address healthcare workforce shortage issues.

This year, VNA will continue to devote its grassroots recruiting, and coordinating, to influence legislators to pass legislation that will improve the education pipeline and create more nurses. As I write this, there are budget amendments that if passed will provide funding for a new baccalaureate nursing school in a rural area of Virginia. As well as create scholarship funds for a new established nursing school in Virginia.

Additionally, a bill has been written that will require transparency and accessibility to the nursing workforce data collected by the Virginia Board of Nursing. Access to data such as this can help us monitor any progress being made towards alleviating the shortage.

Staffing is a complex issue, and one that is at the forefront of concern for nurses and their patients. Assuring an adequate supply of nurses is an important part of the solution.

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Legislated Nurse Staffing Ratios: What You Need to Know

by Pam DeGuzman, RN, MSN, MBA
Commissioner on Policies & Resources

During the 110th US Congress, Senators Daniella Innouye (D-HI), Rep. Ginny Brown-Waite (R-FL) and Rep. Lois Capps (D-CA) co-lead the re-introduction of the Registered Nurse Safe Staffing Act, which the ANA helped to develop. According to the American Nurses Association’s Capitol Update, this bill would “hold hospitals accountable for the development of valid, reliable unit-by-unit nurse staffing plans.”

Unlike legislated staffing plans in states such as California, the bill does not propose a specific numeric ratio. However, if the bill is passed, each facility will have to determine its own nurse-to-patient ratios that will ensure safe staffing. The bill mandates that the staffing levels must be arrived at with input from direct-care registered nurses.

The need for Nurse-to-Patient Ratios

The debate about nurse-to-patient ratios is not new. According to a report published by the Robert Wood Johnson Foundation, efforts to develop legislative policies to improve staffing levels began in the 1990’s. Managed care spurred cuts in many healthcare costs, including the number of nurses providing care. Since that time, shortened hospital stays, higher acuity levels, and an increase in the number of admissions and discharges all have increased nursing care requirements. All of this is occurring just as we are embarking on a critical nursing shortage. Resulting concerns for patient safety have led many states to implement or propose mandated nurse staffing ratios. With federal legislation also pending, it is important to review the reasons for, and concerns with mandating ratios, as well as practices that could substitute for work with these mandated ratios.

Fixed Minimum Ratios: Pros and Cons

The Robert Wood Johnson report, “Three Models of Nurse Staffing Policy,” defines Fixed Minimum Ratios as a model in which, “facilities are required to staff to a certain fixed minimum nurse-to-patient ratio.” According to the report, many nurses look favorably upon such standards because they guarantee a minimum level of staffing on which nurses can depend. The standards may also improve the staffing in hospitals that typically understaff.

Not everyone is favorable about fixed minimum ratios however. The RWJ report also discusses many of the concerns that nurses have, including that the ratios treat a symptom, rather than the cause, of staffing shortages. These standards could actually worsen our healthcare crisis by limiting access to patients in need of care. If a facility could not hire, or afford to hire, to meet the minimum standard they might have to reduce their capacity, thereby reducing their ability to care for patients. Another concern is that hospitals could fire ancillary staff to compensate for the cost of hiring additional nurses. This could reduce the amount of time that nurses have to care for their patients, because they are performing the work formerly performed by ancillary staff.

One thing is clear: more research is needed to determine the efficacy of these standards.

Other Staffing Policy Models

Two other models discussed in the RWJ report are Patient Classification Systems and Pay-for-Performance. Patient classification systems use nursing assessment of patient acuity to determine nurse staffing for each shift, while pay-for-performance models use outcomes data to determine efficacy of nursing care, and reward positive outcomes financially.

Patient classification systems input a nursing assessment of acuity to determine staffing needs. A major advantage of this method is that, since the staffing recommendation is based upon the assessment of the patient by the nurse, some nursing input is used to determine appropriate staffing levels. This method recognizes variability in patients’ needs, as opposed to fixed ratios, which do not account for this variability.

Unfortunately some of the aspects that make this a desirable system for nurses, i.e. having input into the outcome, also draws criticisms. According to the RWJ report, “questions have also been raised about how these systems can be manipulated by exaggerating acuity to justify more staff, resulting in inaccurate record keeping and giving nurse executives and administrators a skewed picture of their units’ activities.”

Another concern with patient classification systems is that there is no standardization; in fact many systems are homegrown. Furthermore, there is a lack of understanding by nurses about how the software works, which may cause nurses not to trust the output.

Pay-for-performance is an emerging model that policymakers are proposing to improve quality in hospitals. Rather than focusing on mandating specific ratios, under this model government programs and/or insurance companies would provide higher payments to facilities that meet or exceed certain nurse-driven quality standards. Facilities would therefore have incentive to provide adequate staffing that would deliver quality outcomes.

Pay-for-performance is still a relatively new model, and before this could be implemented, many issues still need to be flushed out. Some of the questions that remain include how much financial payment would be awarded, which measures would be reported, and which quality measures are truly nurse-sensitive.

These methods, including fixed ratios, can help to ensure safe levels of nurse staffing. However, it may take a combination of methods to truly approach appropriate levels. While the ANA has worked with members of Congress to introduce the Registered Nurse Safe Staffing Act in the 110th Congress, they do have concerns about the fixed nurse-to-patient ratios. According to Michelle Artz, the Associate Director in ANA’s Government Affairs Department, “while such legislated numerical ratios seem to offer a concrete solution, and may appear to be a good fit for some work places, many other variables— including acuity of patients, level of experience of nursing staff, layout of the unit, level of ancillary support—are key to establishing the “right” nurse-patient ratio for any one unit.”

Additional resources


For more information about ANA’s efforts to ensure safe staffing, visit http://www.safestaffingsaveslives.org/default.aspx.

Keep up with the latest nursing issues at the state and federal level at http://www.capitolupdate.org.

References

4. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
8. Ibid.
9. Ibid.
10. Ibid.
11. Ibid.
Questions to Ask

In Making the Decision to Accept a Staffing Assignment

1. What is the assignment?
2. Clarify the assignment. Do not assume. Be certain that what you believe is the assignment is indeed correct.
3. What are the characteristics of the patients being assigned?
4. Don’t just respond to the number of patients; make a critical assessment of the needs of each patient, his or her age, condition, other factors that contribute to special needs, and the resources available to meet those needs. Who else is on the unit or within the facility that might be a resource for the assignment? Do nurses on the unit have access to those resources? How stable are the patients, and for what period of time have they been stable? Do any patients have communication and/or physical limitations that will require accommodation and extra supervision during the shift? Will there be discharges to offset the load? If there are discharges, will there be admissions, which require extra time and energy?
5. Do I have the expertise to care for the patients?
6. Am I familiar with caring for the types of patients assigned? If this is a “float assignment,” am I cross-trained to care for these patients? Is there a “buddy system” in place with staff familiar with the unit? If there is no cross-training or “buddy system,” has the patient load been modified accordingly?
7. Do I have the experience and knowledge to manage the patients for whom I am being assigned care?
8. If the answer to the question is no, you have an obligation to articulate limitations. Limitations in experience and knowledge may not require refusal of the assignment but rather an agreement regarding supervision or a modification of the assignment to ensure patient safety. If no accommodation for limitations is considered, the nurse has an obligation to refuse an assignment for which she or he lacks education or experience.
9. What is the geography of the assignment?
10. Am I being asked to care for patients who are in close proximity for efficient management, or are the patients at opposite ends of the hall or on different units? If there are geographic difficulties, what resources are available to manage the situation? If my patients are on more than one unit and I must go to another unit to provide care, who will monitor patients out of my immediate attention?
11. Is this a temporary assignment?
12. When other staff are located to assist, will I be relieved? If the assignment is temporary, it may be possible to accept a difficult assignment, knowing that there will soon be reinforcements. Is there a pattern of short staffing, or is this truly an emergency?
13. Is this a crisis or an ongoing staffing pattern?
14. If the assignment is being made because of an immediate need on the unit, a crisis, the decision to accept the assignment may be based on that immediate need. However, if the staffing pattern is an ongoing problem, the nurse has the obligation to identify unmet standards of care that are occurring as a result of ongoing staffing inadequacies. This may result in a request for “safe harbor” and/or peer review.
15. Can I take the assignment in good faith? If not, you will need to get the assignment modified or refuse the assignment.
16. Consult your individual state’s nursing practice act regarding clarification of accepting an assignment in good faith. In understanding good faith, it is sometimes easier to identify what would constitute bad faith. For example, if you had not taken care of pediatric patients since nursing school and you were asked to take charge of a pediatric unit, unless this were an extreme emergency such as a disaster (in which case you would need to let people know your limitations, but you might still be the best person, given all factors for the assignment), it would be bad faith to take the assignment. It is always your responsibility to articulate your limitations and to get an adjustment to the assignment that acknowledges the limitations you have articulated. Good faith acceptance of the assignment means that you are concerned about the situation and believe that a different pattern of care or policy should be considered. However, you acknowledge the difference of opinion on the subject between you and your supervisor and are willing to take the assignment and await the judgment of other peers/supervisors.

Adapted from the Texas Nurses Association www.texasnurses.org/wp-content/uploads/StaffingGuide_Conflicts.doc
Pump Up Your Self-Discipline Muscle by Flexing Your Will (and Won’t) Power

by Susanne Gaddis, Ph.D.

Like an athlete in training for a major competition, it took several long years of study, self-discipline and financial sacrifice to train to be RN. In order to study and pass your nursing exams, you made many disciplined decisions to dedicate your time, money and effort in order to achieve this goal. And now that you’ve achieved your admirable objective, do you find that you’re still showing that same steady resolve and fierce willpower in your job?

Pumping up your “willpower muscle” in your day-to-day career can mean a variety of things. Keeping timeliness a priority; making follow-through a must (not a maybe); giving co-workers extra help and effort in a needed area, as well as many other will-powered efforts. And sometimes willpower even means flexing your “won’t power” brawn—using self-restraint, like saying “no thanks” to idle gossip and water cooler-rumors.

“Willpower can be defined as initiating activity, or the ability to do things that are difficult or frustrating. Won’t power is the ability to not initiate activity that you wish to do,” explained Angela Duckworth, doctoral candidate at the University of Pennsylvania and advanced graduate student of nationally recognized ‘Authentic Happiness’ guru Marty Seligman. “Everyone has an intuitive sense of whether or not a person has self-discipline. People can be disciplined about, say, working hard, but find themselves unable to resist other temptations, like procrastination, drinking, gambling and smoking.”

So ask yourself: “Do the goals that you currently have require willpower or won’t power?”

Self-Control as Child’s Play

It’s a scientific fact, self-control can be measured. And it seems that this attribute can show up early in life, sometimes as young as four years of age.

Case in point: Self-control (or self-discipline, self-regulation) can be defined as the ability to delay impulse in the service of a goal (a conquest of the reasoning brain over the impulsive one; a sign of emotional intelligence). The importance of this trait to success was shown in an experiment begun in the 1960s by psychologist Walter Mischel at a preschool on the Stanford University campus.

Mischel told a room of preschoolers that they could have a single marshmallow treat right now. However, if they would wait while the experimenter ran an errand, they would be rewarded with two marshmallows. Some preschoolers grabbed the marshmallow immediately, yet others were able to wait (for what must have seemed an endless) 20 minutes. To sustain themselves in their struggle for self-restraint, some covered their eyes (so they wouldn’t see the temptation), others rested their heads on their arms, talked to themselves, sang, and some even tried to sleep. These determined kids got the two-marshmallow reward.

The interesting part of this experiment came in the follow-up studies. The children who as four-year-olds had been able to wait for the two marshmallows were, as adolescents, still able to delay gratification in pursuing their goals. They were more socially competent and self-assertive, and better able to cope with life’s frustrations. Conversely, the kids who grabbed the one marshmallow were, as adolescents, more likely to be stubborn, indecisive and stressed.

In general, though, infants and toddlers are not good at controlling themselves and that the part of the brain that is implicated in self-control does not really mature in people until the early 20s, Duckworth explained.

Muscle Willpower: A Limited resource

In the simplest of terms, self-control can be viewed as a muscle. Roy F. Baumeister, Ph.D., a professor at Case Western Reserve University, explained that, like a muscle, if you try to constantly (and without respite), exert your self-control, it won’t work. It will wear itself out. In other words, you will fatigue the self-control muscle by over-using it. His recommendation is to exert, and then rest, and then exert, and then rest—in this way you may be able to become more self-disciplined by “growing” your strength.

“From a practical point of view, you can view the model of self-control as a limited resource,” Duckworth said. “If you’re a nurse in a stressful environment, doing things (both emotionally and physically) that you don’t want to, well, after a long 10-hour shift, like any muscle that gets worn-out, you’re more likely to break a self-control mechanism—yell at your spouse, break your diet, and so on. The ‘you’ that most people don’t break their diet and raid the refrigerator at 10 a.m. in the morning. This usually happens at the end of the day when their ‘willpower muscle’ is much weaker.”

A great way to refit your “willpower reservoir” when the tank is running on empty is to catch a nap, listen to a joke, get a hug, watch a funny movie, etc. But there are times when relaxation, sleep, a change in scheduling or a “time out” is not possible. In these times, it may be viable to—rather than change your behavior—change your environment. “As a nurse, you can make an excuse to get out of a difficult conversation, decreasing your self-control demands. You can then postpone the meeting to a time when your self-control reserves are higher… If you’re at the ‘end of your rope,’ then don’t schedule an emotionally difficult session or workout,” Duckworth noted.

Implementation Intentions

It is possible to double or even triple your chance of achieving a specific goal if you pre-think (think ahead and indicate) how you are going to execute the goal. Peter Gollwitzer, Ph.D., does this by having people use specific how, where, when, what objectives, such as: ‘If ______ happens, then I will do ______...’ Now name five things that you need to do: “When it is ______ ______ I will do ______ ______ ______ ______.”

Gollwitzer has people delegate the initiation of goal-directed behavior to environmental stimuli by forming so-called implementation intentions. Again, he uses the: ‘if situation x is encountered, I will perform behavior y’ theory. He has observed that forming implementation intentions helps in detecting, attending to, and recalling the critical situation. Moreover, in the presence of the critical situation the initiation of the specified goal-directed behavior is immediate, efficient, and does not need a conscious intent.

Forming implementation intentions can be used as an effective self-regulatory tool when it comes to resisting temptations, avoiding to stereotype members of an out-group, blocking unwanted goal pursuits and more. Plus, action control via implementation intentions seems to save a person’s self-regulatory resources.

Nine Steps to Develop More Self-Control

According to coping.org (www.coping.org), an onsite manual for coping with a variety of life’s stressors (authored by: James J. Messina, Ph.D., & Constance M. Messina, Ph.D.), there are nine steps to take in assessing, managing and developing your self-control muscle:

(1). First, you need to identify the areas of your life you need to gain more self-control: In your personal life? (balanced diet, love of self, self-esteem, compulsive and/or addictive behaviors [such as eating, shopping, cleaning, alcohol, drugs, sex, smoking, crisis-oriented activity, excessive activity, body image, etc.]). Or do you need to review your relationships with fixes, helpers, caregivers and enablers? (overdependency, manipulation, helplessness, lack of emotional boundaries, etc.) What about your work life? (time & stress management, workaholism, fear of success, assertiveness, self-image as worker, self-recognition of accomplishments, handling perfectionism) And finally your community life? (need for support system, involvement with others, participation in clubs and activities, handling competition & leadership).

(2). Once you have identified the various issues in which you need to develop more self-control, then you need to identify which emotions tend to lead you to be more out of control. Use the list of emotions and feelings clusters to identify for each issue out of control, which emotions or feelings tend to exacerbate the loss of control.

(continued on page 6)
I am hoping that you all will save these dates for the 34th Annual VCNP Clinical Conference which will be at the Hotel Roanoke in Roanoke, VA this year from March 5th until noon on March 8th. There will be five clinical tracks—general practice, acute care, mental health, pediatrics and women's health—filled with great topics and information for you to use each day in your clinical practice. We have many outstanding speakers from Virginia whom we hope you'll support with your attendance. The Government Relations Session will be panel moderated by Mary Duggan, Committee Chair. She will be joined by Jay Douglas, Executive Director of the Board of Nursing and Corinne Dorsey, a former Board of Nursing Director for a look at NP practice in Virginia—the past, present and vision for the future. There will be many opportunities to network with friends and colleagues, and to explore the city of Roanoke. Please join us in Roanoke—the Star City for the 34th Annual VCNP Clinical Conference!

Of course, the General Assembly is under way for a long session this year (until the end of March). VCNP has one priority Bill this year—our NP on the Board of Nursing Bill—SB 63 sponsored by Senator Janet Howell. You may follow the action by going to http://legis.state.va.us and searching for SB 63. Mary Duggan is doing a great job of keeping us all up to date, so as usual, monitor your emails for requests for action and make your voice heard! Other Bills we are following will be found by going to www.virginianurses.com and clicking on Virginia Nursing Associations, then the Legislative Coalition for VA Nurses and looking at the Bills. VCNP is an active member of the Coalition, and you will see many issues being followed that are very important to all of us practicing in Virginia. Our legislative efforts will also be highlighted for the next few weeks at our Regional NP meetings. We are also continuing to monitor the Governor’s Health Care Task Force and will be supporting any recommendations that will improve access to care for our patients and enhance NP practice in Virginia, so stay tuned!

This will be my last letter to you as President of the Virginia Council of Nurse Practitioners. Diane Inlkey will step into this role at our Conference. It has been an honor and my sincere privilege to serve as President for the last two years. I want to thank Diane and the Board for their great work and support during my President’s term.

Best Wishes for a healthy, happy and successful 2008!

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**Emotions that lead to being out of control**

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Feeling cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boredom</td>
<td>listless, unoccupied, restless, uneasy, a need for novelty, change, or excitement</td>
</tr>
<tr>
<td>Anger</td>
<td>rage, hate, cheated, infuriated, spiteful, mean, mad, or envious</td>
</tr>
<tr>
<td>Guilt</td>
<td>ashamed, miserable, remorse, blamed, distraught, or pain</td>
</tr>
<tr>
<td>Depression</td>
<td>left out, ugly, empty, powerless, victimized, suffering, useless, low, sad, helpless, discouraged, or troubled</td>
</tr>
<tr>
<td>Anxiety</td>
<td>overstressed, out of control, nervous, overwhelmed, uneasy, tense, pressured, panicked, troubled, confused, or shocked</td>
</tr>
<tr>
<td>Loneliness</td>
<td>unwanted, unappreciated, left out, ignored, unloved, alone, hurt, neglected, ugly, or rejected</td>
</tr>
<tr>
<td>Fear</td>
<td>afraid, tense, anxious, nervous, weak, worried, skeptical, frightened, threatened, panicked</td>
</tr>
<tr>
<td>Excitability</td>
<td>eager, driven, energetic, capable, turned on, enthusiastic, motivated, or clever</td>
</tr>
<tr>
<td>Comfort</td>
<td>proud, refreshed, appreciated, satisfied, accomplished, useful, respected, content, confident, full, calm, or relaxed</td>
</tr>
<tr>
<td>Happiness</td>
<td>good, nice, glad, loved, pleased, wanted, wonderful, delighted, or beautiful</td>
</tr>
</tbody>
</table>

(Courtesy of coping.org)

(5.) Once you have identified what feelings and emotions tend to exacerbate your loss of control, next identify what irrational beliefs lead to increased loss of control in each of these issues.

(4.) Then you need to identify new, rational, reality-based, healthy thinking, which will lead to your gaining control over these issues. Some self-affirmations are: “I am capable of controlling myself” and: “I will take control of my behaviors,” and: “Changing old behaviors takes effort, time, and a motivation to change and I am willing to give all three of these to gain control of my life.” and: “I am a capable, lovable person who deserves to let go of the uncontrolled ways of my past so that I can grow, flourish, and be successful in my attempts to gain control in my life,” and finally: “I will make time for the work to develop my self-control.”

(5.) Once you have identified healthy self-talk, then you need to identify positive actions or behaviors that will assist you to develop self-control in your life. Such behaviors or actions are: stress reduction, improved time management planning and scheduling, an exercise program five to seven times a week, a balanced diet, altering relationships with people, places and things, keeping a personal journal, changing patterns/routines of daily life, avoid settings that arouse negative emotions, and watch out for HALT (Hungry, Angry, Lonely, Tired) situations which could lead to a relapse of out-of-control behaviors.
Nurses and Continued Competence

by Leslie Herdegen-Rohn, Legislative Coordinator for VNA

How do nurses ensure they remain competent in the ever-changing healthcare environment? New developments in the ways in which nurses are required to maintain competency have occurred over the years. Many states require professional nurses to participate in continuing education (CE) to maintain their license. However, the CE requirements vary widely from state to state, with some states having no CE requirements at all. Virginia, for example, requires only 30 contact hours every two years to renew a license. Other states require considerably more. In Virginia, the Board of Nursing has been reluctant to require CE for relicensure.

The Virginia Nurses Association (VNA) has expressed concern about the lack of CE requirements for nurses: nurse practitioners must demonstrate continued competence for prescriptive authority, and RNs are required to be certified by their specialty organization or show that they have received a certain number of hours of continuing education to renew their LPN license. These requirements are enforceable law in Virginia.

But RNs do not have any such legal requirement. Various specialty organizations and some employers require them to attend educational sessions, but there is no law stating this must be done. In Virginia, nurses demonstrate minimum competency when they apply for initial licensure, but RNs and LPNs do not. Virginia requires that nurses demonstrate minimum competency when they apply for initial licensure, but RNs and LPNs do not.

How, then, do nurses ensure that they remain competent? Most nurses take seriously the need to remain both up-to-date and expert in their fields, but do so through professional credentialing, leadership activities, ongoing practice and on-the-job experience and learning, professional reading, and continuing education. In Virginia, there is widespread disagreement about the efficacy and measurability of continuing education. Two groups currently are looking at these CE requirements: the Attorney General’s Commission on Regulatory Reform and the Board of Nursing, the umbrella group for all health professional licensure boards.

In plain terms, the question is how to assess knowledge, critical thinking, communication related to patient care, and professional judgment and ethics at the time of relicensure. While all agree that this should be an important component of consideration for health professional relicensure boards, the underlying disagreement is how to do it.

Let’s look at each of the areas that could be used to evaluate continued, not initial, competence: professional credentialing, leadership activities, ongoing practice and on-the-job experience and learning, professional reading, and continuing education, as well as the question of retesting.

Professional Credentialing

Professional credentialing would include such things as an unencumbered license, specialty or advanced practice certification, post-licensure academic coursework, workshops, and certificates. These criteria obviously are easy to measure accurately, and ensure that the relicensure applicant has proven to be able to demonstrate the necessary body, or a licensing board that they have successfully completed the requirements. So, these would be good objective criteria, but all of them with the exception of an unencumbered license come with additional cost—sometimes a substantial cost.

Leadership Activities

Leadership might include such things as participation in workplace committees, service with or local boards or committees, preceptorship, presentations, or volunteer activities related to healthcare. The relationship between leadership activities and maintaining competency is sometimes complex. Some areas where clearly there is a nexus (i.e. service on a quality assurance committee at work) and some areas where it is not (e.g. whether service as the Treasurer of the Virginia Nurses Association adds to your professional competence). Obviously, the cost of these activities is minimal, but the measure of the quantity, quality, and assurance of continued competence is less objective.

Ongoing Practice and On-the-Job Experience and Learning

There is no question that continuous good practice is one of the best assurances of continued competence. However, the repeated bad practice (i.e. repetition of inappropriate, substandard or just wrong practices) probably is closely associated with a decreased competence. Nurses most often function as part of a healthcare team, the latter is less likely to occur; however, we all know of situations when it does. We also know of employers who stress on-the-job experience and learning, and offer opportunities for nurses to participate (or even require participation), we also know that this is not always the case.

So, while ongoing employment with its related opportunities is one of the least costly and most effective, or just an overly burdensome requirement: to evaluate continued, not initial, competence, it is not necessarily reliable.

Professional Reading

There are few nurses who do not subscribe to professional journals or read them in libraries or elsewhere. There is no question that professional reading is valuable, but it is only one component of the overall competency one brings to the profession. Leadership activities, subscriptions to journals, and continuing education. Which of these is most effective, most cost-effective, and most objective, to ensure the continued competence the public expects? Despite the fact that all other professionals in Virginia have a continuing education requirement, there is widespread disagreement about the efficacy and measure of continuing education. Two groups currently are looking at these CE requirements to determine whether they are effective, or if there is a burdensome requirement: the Attorney General’s Commission on Regulatory Reform and the Board of Health Professionals, the umbrella group for all health professional licensure boards. During the 2007 session of the Virginia General Assembly, a bill was introduced to require RNs and LPNs to have met certain continuing education requirements as a condition for license renewal. The chief patron said he introduced the bill at the request of a nurse constituent who believes that nurses of learning is absent, and there is no good way to measure it reliably. And, the cost of subscriptions is often high, or included in the cost of a membership, which is also price. While there are ways to minimize this cost, they are significantly less expensive than subscriptions and continuing education. Nurses are less likely to take advantage of these written materials.

Continuing Education

This is the crux of the discussion. In state after state, for profession after profession, continuing education is the accepted measure of continued competence. But, in reality, it is a good measure, and do the benefits outweigh the costs? That is the question for nurses and other professionals in Virginia, in other states across the country, and for other professional organizations. It also is the question being discussed by the Attorney General Task Force and the Board of Health Professionals.

Continuing education is the most commonly used method to indicate continued competence for other professionals in Virginia and across the country. It is easy to objectively assess and document, making it a measure that can be used well by licensing boards as an indicator of continued competence for relicensure. But how does the cost-benefit analysis stack up? Over the years, a number of studies have produced results to demonstrate that CE does not substantially improve patient outcomes. It is widely believed that this is due to the passive learning nature of most CE courses and the fact that professionals are often required to attend the educational sessions, although there is no empirical evidence to support these hypotheses. Yet, a February 2007 literature review by the Johns Hopkins Evidence Based Practice Center: the literature overall supported the concept that CME was effective, at least to some degree, in achieving positive outcomes and maintaining the objectives studied, including increasing knowledge (22 of 28 studies), attitudes (22 of 26), skills (12 of 15), practice behavior (61 of 105), and clinical practice outcomes (14 of 33). So, there is no conclusive evidence on efficacy of CE.

The Attorney General’s Regulatory Review Commission is looking at a study in progress that we believe will demonstrate the cost of CE is high, particularly when tuition and lost income both are considered. If this study should produce the results we expect, it will be an interesting analysis as to whether continuing education is a cost-effective way to measure continued competence.

One More Option: Testing

One of the other options sometimes discussed as a method to ensure continued competence is retesting. Often, those who propose retesting are not clear about what test must be retaken for license renewal, although some commonly assume it is the exam for initial licensure. Few professionals believe this is appropriate. The exam for initial license for all health professionals is broad, reflecting their education and training. Most professionals go on to work in a specific field and may never confront many of the situations they learned during their educational careers. Alternatively, many of the certification bodies require periodic retesting only in the specialty area, and these exams could be used, although if certification were required, it would significantly increase the cost for health professionals, including nurses.

Summary

All nurses would agree that continued competence is a vital part of safe and effective nursing practice. Nurses also generally would agree that some way to ensure continued competence at the time of license renewal is important. Yet, it appears that there is not agreement on the best way for the Board of Nursing to accomplish this goal.

VNA will deliberate its position on continued competence as the groups studying this move forward. As we do so, we welcome any thoughts that you might have. Just send them along to our Executive Director, Susan Motley, at smotley@virginianurses.com.
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There are questions that each and every one of us asks ourselves from time to time. These include “Who am I?” “Why am I here?” “Where am I going?” and “What really matters in life?” These questions take on a particular significance to someone diagnosed with an illness such as cancer. There is a tendency to go through life shielding ourselves from certain realities such as our mortality. Cancer prompts us to be in touch with our vulnerabilities. Cancer may also force us to reflect on all the possibilities that our present life has to offer in our relationships with each other and to a higher authority, the horizontal and vertical so to speak.

A diagnosis of cancer leads people on a search for meaning which has more to do with a growing need for spirituality, rather than religion. Some people use the words spirituality and religion synonymously, but really they are different. Religion may be defined as a specific set of beliefs and practices, usually associated with an organized group, in other words, grounded in specific rules. Spirituality on the other hand has no ground rules, no formal belief system or doctrine; it is a connection to all that is universal. Spirituality may be defined as an individual’s sense of peace, purpose, connection to others, and beliefs about the meaning of life. While many find solace, comfort and support in their particular religion, there tends to be a greater opportunity to find meaning in one’s personal spirituality, and it indeed is personal.

A wonderful analogy I discovered for one’s spirituality was from nurse and author of Mind, Body, and Soul: A Guide to Living with Cancer Nancy Hassett Dahm. She likened the depth of one’s spiritual connection to being in the shallow end of a pool. “You may explore various depths, and often marvel at seemingly limitless unanswered questions and mysteries, until you accept that the far end of the pool is really the boundless, deep end of a magnificent ocean.” Ms. Dahm asks the question “Why is it important to have a sense of spirituality?” Personally, and in my years of being an oncology nurse, I agree with her that it definitely is important, because it will help you live better and to live with a heightened sense of hope and meaning. There is a beauty to spirituality as it enables you to create your own private place of being. It is “contemplating anything and everything in relation to your sense of being; finding personal significance in the seemingly insignificant, to that which holds the greatest significance”.

Author Dahm has used the work of philosophers Socrates and Plato to give her a greater sense of spirituality. Because philosophy is “grounded in logic” and is “universal, non-sectarian and speaks to the soul of most of us who are uncertain or fearful of the mysteries of life and death,” the ideas of these philosophers are what folks may need to find connection to each other and to the universe. “Philosophy serves as a moral compass, teaching us the many ideals of a meaningful and purposeful life and the permanence of the soul.” Ms. Dahm says that by reading these philosophers, you may be taken “from the shallow end of the pool to the deep end of spiritual comfort.”

As you may have guessed by now, I was very moved and touched by this author. I so identified with Ms. Dahm as she verbalized, as a noted author could, that which I could not in all my own years as an oncology nurse. Rather than paraphrase, I will quote her directly: “I realized long ago (in our caring for those with cancer) that people need to feel their life mattered in a significant way. I felt a responsibility to show them that indeed, they are loved and part of us all. Finding a way to bring them the peace of mind they could not give themselves took me on a search for greater spirituality. It was for myself as much as for them. In helping others I was finding my own way, my own road to understanding.”

Herein lies my involvement with Life with Cancer’s Spirituality Quest Group that meets monthly at the Juniper St. Family Center. When the group originated fifteen years ago, the book Man’s Search for Meaning by psychiatrist and Holocaust survivor Viktor Frankl was discussed. Frankl firmly believed that every human person is a being who is transcendent and that the basic drive for a person is not pleasure or power but meaning. That is the essence of the Spirituality Quest Group. We are on a quest for the meaning in our lives, both personally and collectively; we look at how a cancer diagnosis impacts that meaning and how we can find peace in the midst of chaos and crisis. We have many storms of life that darken our skies and have to be buffeted: physical, mental, financial, the list goes on, but when we can find a place to feel grounded, supported and safe, wherever that place may be. In the Spirituality Quest Group, you will find a sense of peace and comfort and feel transcended!”

### Alternative Approach

**Spirituality and Cancer**

by Marsha Komandt, RN, BSN, OCN®

Oncology Education Coordinator

Life with Cancer®
When the State Board Calls: Part I

Guidance from Nurse Attorney, Latonia Denise Wright

Diane E. Scott, RN, MSN

Every week, Latonia Denise Wright, R.N., B.S.N., J.D., is contacted by a nurse seeking advice about a letter or a phone call received from a State Board of Nursing or Virginia General's Office of Consumer Protection alleging an infraction. The advice is based on an understanding that state boards may have received several months to a year before the nurse is contacted.

As an attorney licensed in Ohio, Kentucky, and Indiana, Ms. Wright has often encountered a nurse's anxiety and panic surrounding State Board disciplinary investigations. Ms. Wright spoke with the Virginia Nurses Today about the nursing world.

The Center: Why would a State Board investigate a nurse?

Ms. Wright: Many nurses may not fully realize that the role of any Board of Nursing is to protect the public from unsafe nursing care. The vast majority of nurses interact with their State Board in a non-adverse manner. Your financial plan and whom it is to the best interest.

The State Board of Nursing has the authority to issue a complaint in writing in those cases in which a registered nurse is not in compliance with the Nurse Practice Act and Board's Rules of Practice regulations in the Board of Nursing.

The Center: When should a nurse contact an attorney?

Ms. Wright: While representing overall as a nurse's rights in court seems minimal, it is difficult to maintain one's competence, remains objective, and act as his or her best interest of all times when processing the others or no or merely representing. Many times, it may not only seek legal advice, but may also be asked to provide the Board with any information from a person or other relevant witness.

What matters are or engaged by the initial phone call from the State Board, they do not fully comprehend the ramifications of their response. Although the investigation's conversations may be described as "clinical" and may be rather short, a nurse may still need to be cautious of every response and retain the right to represent prior to answering any questions.

The Center: What about the cost of an attorney?

Ms. Wright: A nursing license is how you support her family. It is that Board. Making an informed decision to retain an attorney is crucial. A State Board of Nursing disciplinary investigations and adjudications can impact a nurse's livelihood as well as her career.

While professional legal advice is not free, it is imperative, employment and professional ramifications of being investigated and having no attorney is common concerning one's financial and legal situation. Filing a written request for a pre-trial conference can help determine the need for further investigation or assistance. What many nurses do not realize, is that their professional liability insurance may pay for legal counsel in many cases.

The Center: Should a nurse carry their own liability insurance?

Ms. Wright: Your significant revenue means to manage exposure and liability for healthcare professionals is to purchase professional liability insurance. If you do not have insurance, as it only affects the practice of a nurse and has gone off course. Some nurses are represented by their state or national associations. One nurse may be represented by their state or national association while another nurse may be represented by their state or national association. However, if you are represented by your state or national association, you may be required to pay a fee to represent your state or national association in the event of a complaint.

The Center: Can a nurse have a license suspended or revoked?

Ms. Wright: By revoking a professional liability policy, a nurse is prevented from the nurse they are named as a defendant in medical malpractice and to the state board's complaint. If the complaint is filed against the nurse and Board of Nursing.

When purchasing a policy, make sure that it covers attorney fees and court-related Board of Nursing disciplinary investigations. Nurses should consider purchasing an insurance policy for an attorney that will pay the rates and other financial professionals as the policy similarly include coverage for professional liability, license renewal, and deposition representation.

The Center: In closing, how do I find a licensed attorney?

Ms. Wright: Contact your state nurse association or refer to the Virginia Nurses Today. You can contact the American Association of Nurse Attorneys (www.aaona.com).

This Nursing That Works article is not intended to take the place of your professional legal advice. For more information, please contact your state Board of Nursing, state nurse association, or contact a licensed attorney in the state in which you are licensed.

If you have any questions, contact the Virginia Nurses Today at 804-322-0777 or email info@virginiannurses.com.
The clinical laboratory content includes Applying Principles of Safe Patient Handling and Movement (SPHM, part of the toolkit) and Assessment Criteria and Care Plan and Standard Safe Patient Handling and Movement Algorithms (part of the didactic assignment).

The objectives are:
1. Assess patients to select the right combination of equipment and personnel needed to handle or move them safely.
2. Apply positioning and mobility techniques that are safe for patient and caregiver.

In teaching students the proper contemporary techniques to move and handle patients and use of a variety of electronic and high-tech equipment in the practice skills lab and then during clinical times, the students assume a set of expectations that ensure safety. The students can accept the role as change agents and be proactive in determining elements in their practice environment. Organizations that provide a positive work environment, innovative technology, strong leadership, and maintain a focus on patient centeredness and employee safety have higher employee satisfaction, fewer vacancies, and less turnover of staff (Stone & Harrison, 2005).

We must provide the information about Minimal Lift Environments to as many nurses as possible and in as many ways as possible. The transformation to a culture of safety is steady, sure, and incremental. Gradually changing over patient safety lift equipment using staff trialing the equipment and input into the equipment selection process are critical factors in process acceptance and long-term compliance. Nurses who enter the workforce with the knowledge of the principles and the skill sets will advance the cause of minimal lift environments.

References


The application must include the application, two supporting recommendations, an official transcript, and the essay. The essay must be mailed and postmarked no later than April 18th. Incomplete packets will be considered ineligible. The scholarship recipients will be expected to attend our District 5 meeting and program in May to receive their awards. For additional information, please contact Beverly Ross, RN, Scholarship Committee Chairperson, at (804) 675-5389.

The application is also available from the VNA Website: (virginianurses.com) with the Link to District 5.

Attention all RNs!

Are you reading this at 3:00 a.m.? Did you drag yourself out of bed to do this?

Are you tired from driving all over the county seeing patients?

Be an agent of change for your profession.

Help answer the question of how fatigue impacts you and your job by participating in this survey. All answers will be kept confidential and reviewed by the research staff only.

VNA has endorsed doctoral dissertation research by Linsey Barker, an Industrial and Systems Engineering student at Virginia Tech.

Please go to our website at www.virginianurses.com to take our short survey.

Thank you! Your participation is critical for the future of the nursing profession.

You can also help by forwarding this survey to your colleagues.

www.VirginiaNurses.com

VNA — Working For You

Commission on Nursing Education

by Jennifer Mathews, PhD, CNS-BC
Commissioner on Nursing Education

Since the 1990s, the Institute of Medicine (IOM) has published a series of reports that highlight aspects of the healthcare delivery system. Among these are: Crossing the Quality Chasm, To Err Is Human, Keeping Patients Safe, and others. The central ideas are quality and safety for the patient and improved work environments and work designs for the healthcare provider. Much has been written about these reports and these have been formalized into action plans: the National Patient Safety Goals, established yearly since 2003, are based on the IOM recommendations and continual input from consumers and providers. The translational use of these findings and reports occurs through The Joint Commission for the Accreditation of HealthCare Organizations as it sets mandates in the accreditation of healthcare organizations.

The IOM and the American Nurses Association (ANA, 2006) endorse the inclusion of the IOM concepts and competencies into the education curriculum provided by schools of nursing. It is now time in the Commonwealth of Virginia for the Schools of Nursing to continue the integration of these concepts and ideals into the curriculums to benefit the students, nurses, the patients, and the healthcare system. One component of the recommended changes is Work and Worksite Design to Prevent and Mitigate Errors. The didactic content requires assigned readings of healthcare ergonomics. The objectives are:

1. Define healthcare ergonomics.
2. Recognize high-risk patient care activities.
3. Identify risks in patient care environments.
4. State why mechanical aids are needed when moving and handling patients.
5. Use algorithms to identify safe patient handling and movement strategies.

The clinical laboratory content includes Applying Principles of Safe Patient Handling and Movement (SPHM, part of the toolkit) and Assessment Criteria and Care Plan and Standard Safe Patient Handling and Movement Algorithms (part of the didactic assignment).
CE Fees

Continuing Education Approval (CEA) Committee of the VNA is an accredited approver of continuing education by the American Nurses Credentialing Center (ANCC). The tasks of this body include reviewing provider applications, and approving educational activity applications for conferences. The CEA Committee accomplishes these important tasks through the dedication of loyal and diligent committee members who volunteer their time and talent.

After careful consideration the CEA Committee is redefining how the fees for CE approval (single activities) will be calculated. Beginning on February 1, 2008, the fees will be based on the number of contact hours reviewed, not on the number of contact hours the participant will receive.

There is a $20.00 charge for each topic in a concurrent session in addition to the contact hour fee. For example a participant may receive 7 contact hours for a program, but the actual content of the program may be 10 contact hours. The fee for this program would be $200.00. This is most often realized when concurrent sessions are provided.

Example:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Contact Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:30 am</td>
<td>General Session (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>9:30-10:30 am</td>
<td>General Session (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>10:30-10:45 am</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>10:45-11:45 am</td>
<td>General Session (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>11:45-12:45 pm</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>12:45-1:45 pm</td>
<td>Concurrent Sessions Topic #1 (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>1:45-2:45 pm</td>
<td>Concurrent Sessions Topic #1 (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>2:45-3:00 pm</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>3:00-4:00 pm</td>
<td>Concurrent Sessions Topic #1 (1 contact hour)</td>
<td>1</td>
</tr>
<tr>
<td>4:00-5:00 pm</td>
<td>General Session (1 contact hour)</td>
<td>1</td>
</tr>
</tbody>
</table>

This program is designed for nurse practitioners, nurses, dietitians and other health care professionals interested in the management of women with diabetes during pregnancy and the long term implications of gestational diabetes. The conference will examine the pathophysiology of diabetes, medical management in pregnancy and beyond, nutrition, exercise, medications and cultural considerations. The registration fee is $100.00, which includes lunch and CEU credit. To register or for more information contact: gdm@virginiadiabetes.org

Gestational Diabetes Conference

Alleghany Regional Hospital hosted regional healthcare leaders and representatives from the Institute for Healthcare Improvement (IHI) in October, 2007, to discuss progress made with a number of significant healthcare improvements. ARH was chosen as one of many sites to visit in a nationwide tour of all 50 states and the District of Columbia. The “Fall Harvest” tour was an opportunity to learn about and gather notable results from hospitals taking part in the 5 Million Lives Campaign, which asks hospitals across the country to implement up to twelve healthcare interventions in order to protect patients from five million incidents of medical harm. Alleghany Regional Hospital highlighted their progress on six different processes including: the implementation of rapid response teams for non-ICU patients who become acutely ill; acute myocardial infarction (heart attack) care; bundling of precautionary steps to prevent pneumonia for ventilator patients; bundling precautionary steps to prevent central line infections; preventing surgical site infections; and reconciling medication lists especially for patients transitioned to another area. “This visit from the Institute was a great honor for our facility,” explained Robin Broughman, Chief Nursing Officer for the hospital. “Being chosen for this site visit reinforces our progress and recognizes our high quality scores.”

Alleghany Regional Hospital is a member of HCA Virginia, a network of locally managed hospitals, surgery centers, and outpatient diagnostic and treatment facilities in central, southwest, and northern Virginia.

Other HCA facilities within the Southwest Market include Lewis-Gale Medical Center, Salem; Montgomery Regional Hospital, Blacksburg; and Pulaski Community Hospital, Pulaski. With an inter-facility transfer program and electronic patient records that physicians and staff can access from any HCA hospital, the HCA network delivers patient-focused, cost effective healthcare, continuously improving quality and utilizing resources effectively.

Gestational Diabetes Conference

The Virginia Diabetes Council is pleased to announce it will sponsor “Gestational Diabetes and Beyond” on Saturday, May 17th from 9:00 a.m. to 4:00 p.m. at Inova Fairfax Physicians Conference Center, Falls Church, VA.

This Continuing Education Program is designed for nurse practitioners, nurses, dietitians and other health care professionals interested in the management of women with diabetes during pregnancy and the long term implications of gestational diabetes. The conference will examine the pathophysiology of diabetes, medical management in pregnancy and beyond, nutrition, exercise, medications and cultural considerations. The registration fee is $100.00, which includes lunch and CEU credit. To register or for more information contact: gdm@virginiadiabetes.org.
Pinning Ceremony at Thomas Nelson Community College

Eight Thomas Nelson Community College students, the first completers of an Associate in Applied Science in Nursing Program from the College’s Historic Triangle campus, were acknowledged in a Pinning Ceremony on Saturday, December 15 at the España Conference Room on the College’s Hampton campus. A symbolic, but meaningful event, the Pinning Ceremony marked a new facet in the personal and professional lives of the graduating Nursing students, said Mary K. Howard, chair of the Nursing Department. The ceremony also symbolizes the students’ commitment to the profession. During the ceremony, the nurses promise to practice their profession faithfully, aid the physicians in their work, and devote themselves to the welfare of those committed to their care.

“The Nursing faculty is very proud of the students’ efforts and dedication,” Thomas Nelson Community College with the support of organizations such as the Williamsburg Community Health Foundation is playing a major role in addressing the national shortage of nurses especially in our communities,” said Howard.

Nursing graduates from the College make up a large percentage of nurses working in area hospitals, she noted. Students are diverse in many ways and many of them have overcome obstacles and challenges in life to follow their professional dreams, she added.

Thomas Nelson Community College began offering Nursing at its Historic Triangle campus in 2006 aided by a grant from the Williamsburg Community Health Foundation. The grant enabled the College to offer an Accelerated Evening/Weekend Licensed Practical Nurse to Registered Nurse Articulation Program, an RN Associate Degree in Nursing Program and also funded laboratory equipment purchases and Nursing scholarships. The College received a second grant last year for continued scholarship funding and implementation of several programs and initiatives such as Spanish Language Skills for Emergency Healthcare Providers, Phlebotomy Career Studies Certificate Program in Williamsburg, continuation of funding for a TNCC Historic Triangle Nursing faculty positions and continuation of funding for Nursing student scholarships.

For additional information about the Nursing programs available at the College’s Historic Triangle campus, please contact the College’s Nursing Department at 757-825-2808.

BB&T, Inova & Marymount University Address the Nursing Shortage

The nursing shortage in the Washington, DC, region and across the nation continues to be a serious concern. With the baby boom generation aging, the need for nurses is only going to increase. The U.S. Bureau of Labor Statistics has projected that more than 1.2 million new and replacement nurses will be needed by 2014. Virginia Nurses Today reports that Northern Virginia will suffer an increase of 16,600 vacant positions for healthcare workers, primarily nurses, by 2020. Healthcare providers and policy-makers believe aggressive interventions are needed to encourage and support individuals considering careers in nursing.

In response to this very serious nursing shortage, Branch Banking and Trust Company (BB&T), Inova Health System, and Marymount University have joined forces to encourage men and women to enter the nursing field by earning a second bachelor’s degree—this time in Nursing.

Last spring, BB&T provided Marymount with $7,500 to establish a scholarship fund to benefit individuals in the University’s second-degree Bachelor of Science in Nursing program. Each year, the fund’s interest will be matched by philanthropic gifts raised by Inova’s foundation, and the combined dollars will be made available for scholarships. The BB&T/Inova Scholarship benefits students in the second year of their program. (Most individuals with a prior bachelor’s degree can complete Marymount’s second-degree Nursing Program in just 15 months.) The scholarship criteria include a grade point average of 3.0 or higher, submission of an application and essay, and a commitment to work for the Inova Health System for at least two years after graduation.

Now, the first eight BB&T/Inova Scholarships of $7,500 each have been awarded, and the recipients were recognized at an Inova Nursing Scholars reception on November 14 at the home of Carl and Jeannette Biggs in Vienna, Virginia. Mr. Biggs is chair of the Inova Health System Board of Trustees and a member of the Inova Health System Foundation Board.

The recipients of Marymount’s BB&T/Inova Scholarships for the academic year 2007-08 are:

Sadie Downey of Alexandria (grew up in Edinboro, PA): Previously a fitness specialist, Downey views nursing as a way to make a difference: “I may not be able to change the world, but I can work to keep individuals in the world healthy,” she explains. Upon graduation from Marymount, she will be a labor and delivery nurse at Fairfax Hospital. Downey also plans to continue her education and eventually teach at the university level.

Kathleen Gleason of Alexandria: Passionate about starting her nursing career, she says of her future employment with Inova, “As a native of Northern Virginia, I grew up in the very community served by Inova. It means so much to me to be a part of this nationally acclaimed organization and serve my home community.” Gleason’s long-range plans include a master’s in Nursing, possibly becoming a nurse practitioner. She is currently interested in medical-surgical or emergency room nursing.

Cara Freer Haire of Arlington (grew up in Richmond): Haire holds a master’s degree in Healthcare Administration, and that background has led her to nursing. Long interested in the field of women’s health, she looks forward to becoming a labor and delivery nurse. As a student, she has been working in the labor and delivery unit at Inova Fair Oaks Hospital and thoroughly enjoys the work and atmosphere. With a job now secured after graduation, she adds, “I am interested in the further education that Inova offers, like the certification to become a lactation consultant.”

Lauren Havard of Fairfax: Nursing was always Havard’s career choice. While working on her first bachelor’s degree, she was also on the swim team, which made it impossible to fit clinical rotations into her schedule. So Havard earned her first degree in Exercise and Sport Science, but she always planned to return to study Nursing. “I want to be a nurse because I have a strong desire to contribute to improving the health and well-being of others,” she explains. “This scholarship means finally being able to accomplish my lifelong dream I would love to work in pediatrics or labor and delivery with Inova.”

Heather Mogg of Woodbridge: A registered dietician, Mogg has now chosen nursing as a career because “it’s a rewarding, dynamic, and challenging field that offers specialty areas and opportunities for advancement.” After graduation in December 2007, she will work in the neonatal intensive care unit at Inova Fairfax Hospital. Mogg eventually wants to earn a master’s degree and certification as a neonatal nurse practitioner.

Jessica Roberts of Fairfax: With a BA in Communications from Fordham, Roberts is making the transition from marketing to nursing. “Being in a position to help someone is such a rewarding, fulfilling job,” she says. “This scholarship means more to me than anyone can ever know,” says Roberts. “It validates all of my hard work!” She has accepted a position with the Inova Heart and Vascular Institute’s bridge program. “In this program,” she explains, “I will start my nursing career in the coronary care unit and, over the course of a couple of years, my training will bridge over to the cardiovascular intensive care unit.” Thinking long range, Roberts adds, “One day, I will return to my master’s degree. In addition, I’ve thought about becoming a Nursing professor.”

Shailly Thapa of Reston: Formerly a social worker and case manager with MICA (Mentally Ill and Chemically Addicted) services in New York, Thapa now looks forward to working as a nurse in pediatrics. Nursing is a natural career path for Thapa, who says, “I have always wanted to work with people and always believed in making a difference.”

Jessica Wood of Oak Hill: Inspired by her mother, who is a nurse practitioner, Wood began Marymount’s second-degree Bachelor of Science in Nursing program right after graduating from Virginia Tech. She enjoys learning through each clinical rotation and says, “I’m currently looking forward to working with infants, especially in the neonatal intensive care unit at Inova Fair Oaks Hospital for Children.” Eventually, she would like to become a family nurse practitioner. Wood adds, “Not only will this scholarship help relieve my financial burden, it is also a stepping stone to a brilliant nursing career with the Inova Health System!”

The BB&T/Inova Scholarship at Marymount University is an effort to attract college graduates to the nursing profession. “Generally, there’s very little tuition assistance available for students working on a second baccalaureate degree,” explains Dr. Tess Cappello, dean of Marymount’s School of Health Professions. “Not only do these scholarship recipients receive financial support, they also have jobs waiting for them when they graduate.”

At the Nursing Scholars Reception, John Toups, chair of the Inova Health System Foundation Board of Trustees, added, “We get the brightest and best nurses through these scholarships. When I think back on the nurses I’ve hired over the years, it’s the nurses I remember. Thank you all for going down this road.”
In October, VNA District 2 held a CE program: Political Advocacy for the Nursing Workforce. VNA President Terri Haller and Legislative Chairman Sallie Eissler presented. Attendees were treated to workforce information and our legislature agenda.

District 4

The February meeting of District 4 was held on February 21 at Norfolk State University. The meeting was dedicated to graduating nursing students. The program focused on preparation for licensure and managing the transition from nursing student to professional nurse.

Discussions included NCLEX-RN Test plan, licensure requirements, permission to work as an RN applicant, job interviews, orientation and preceptorships. Area healthcare agencies, book vendors, military organizations and educational institutions provided information and incentives to students.

Because February is Black History Month, a PowerPoint presentation provided a historical perspective on Virginia’s African American nurse leaders, professional associations and educational institutions. Continuing Education units were also provided.

For further information, contact Dr. Bennie L. Marshall, President of District 4 at blmarshall@nsu.edu or 757-823-9015.

District 5

District 5 VNA is very proud to announce its new President for 2007-2008. Rocquel Crawley has happily stepped in to complete the term of former President Joanne Casazza.

Ms. Crawley has successfully served as Vice-President of District 5 for the past two years. She has brought excellent speakers to the District 5 Meetings and has assisted with increased participation from members.

Ms. Crawley was recently recognized for her excellence in leadership by her staff. Her staff has described her as ‘demonstrating excellent management skills in her role as the nurse manager for Women’s Health in the Ambulatory Clinics. Under her leadership, with measurable outcomes for her management style, patient satisfaction has skyrocketed. She has been a tremendous asset to Women’s Health since she first arrived last year. She has made many positive changes that have resulted in a significant increase in overall quality of care. She has achieved this excellence in patient care by empowering her staff. She has changed the culture of the workplace. As a result of her vision, Women’s Health in the VCU Health System Ambulatory Care Clinics is a Shining Star.’

Ms. Crawley also has a vision for the continued progression of our District toward achieving excellence for our membership. The Board of Directors and Officers of District 5 will meet for its annual retreat on August 18th at VNA Headquarters in order to develop a Strategic Plan for the forthcoming year.

Our president has a mantra: ‘Excellence is a habit, not an Act.’ We look forward to a challenging and fulfilling year under Ms. Crawley’s leadership.

District 12

District 12 welcomed Amanda Rosenkrenz MSN, RN, Program Manager for the Center for American Nurses to their November 2007 membership meeting. Amanda spent time enhancing our district’s education to the “Center” which included the “Workforce Eco-system” concept of five areas surrounding the nurse: 1) Staffing, 2) workflow design, 3) personal/social factors, 4) physical environment and 5) organizational factors (culture). Amanda also informed us about the resources available to ANA-VNA members (i.e. lateral violence and bullying in the workplace to name a few).

Amanda also has a vision for the continued progression of our District toward achieving excellence for our membership. The Board of Directors and Officers of District 5 will meet for its annual retreat on August 18th at VNA Headquarters in order to develop a Strategic Plan for the forthcoming year.

Our president has a mantra: ‘Excellence is a habit, not an Act.’ We look forward to a challenging and fulfilling year under Ms. Crawley’s leadership.
In Memoriam

Virginia L. “Cookie” Wagner, 65, of Afton died Saturday, December 22nd, 2007. The Nightingale Tribute was read at the January funeral and included roses. Many nurses were in attendance and appreciated the tribute that was given their friend and colleague.

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Letter To the Editor

I must admit I held my breath a bit when reading “Nurses and Continued Competence” in the latest newsletter. I had expected to see that continuing education was “the answer.” I am very impressed to read such a reasoned discussion of this exceptionally complex issue. I would like to add a couple of points. First, it may be that mandatory continuing education not only fails to improve care, but also that, by increasing costs across the system, it may diminish access to care. Second, the role and responsibility of employers in ensuring continuing competence needs to be explored. Third, Canadian nursing organizations have done some intriguing policy work on this subject which is well worth reviewing. Some references can be found in Lundgren, B.S., and Houseman, C. (Winter 2002). Continuing competence in selected healthcare professions. Journal of Allied Health, 31:4

Sincerely,
Burt Lundgren
Burt Lundgren, MPH, PhD, RN
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School of Community and Environmental Health
College of Health Sciences
Old Dominion University
Norfolk VA
blundgre@odu.edu

Welcome New & Returning Members

District 1—Far SouthWest
Kristin Cannon
Pamela Elmore
Sidney Hairston

District 2—New River/Roanoke
Regina Cowles
Marjorie Craighead
Charlene Jordan
Katie Katz
Margaret Semple

District 3—Central Virginia
Lindsey Cardwell
Tiffany Clark
Connie Schieck

District 4—Southside Hampton Roads
Virginia Bailey
Joanne Bock
Kathleen Burton
Bertethia Cromwell
Jennifer Gottlieb
Mary Graham
Renée Hamilton
Lisa Holden

District 5—Richmond Area
Robin Allison
Jessica Brabrand
Kerin James
Carter Lineweaver
Carol McDonald

District 6—Mid-Southern Area
Susan Follette
Lisa Simpson

District 7—Piedmont Area
Karen Bloomfield
Michael Cary, Jr.
Ahmad Ismail

District 8—Northern Virginia
Beverly Atkinson
Shannon Blankenship
Theresa Brosche
Jennifer Chaikin
Deborah Chappin
Caroline Credille
Cathy Duncan
Karín Espleman
Sally Glover
Ruth Harris
Mary Hess

District 9—Mid-Western Area
Mary Bowser
Bonnie Caplinger
Debra Carter

District 10—Peninsula Area
Julie Christensen
Rebecca Gray
Brenda McCullen

District 11—Eastern Shore
Jennifer Boston
Catherine Donovan
Mary MacNeill

District 12—Northern Shenandoah Valley
Tonya Cheek
April McClain
Alison McNeill
MEMBERSHIP APPLICATION

State Nurses Association Membership Application

MEMBERSHIP NEWS

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Last Name/First Name/Middle Initial Home Phone Number

Credentials Work Phone Number Basic School of Nursing

Preferred Contact: Home _____ Work _____ Fax Number Graduation (Month/Year)

Home Address Date of Birth RN License Number/State

Home Address City/State/Zip

City/State/Zip County

Employer Name Member of Collective Bargaining Unit other than UAN?

Employer Address

Employer City/State/Zip Code

Employer Code ______________________

Membership Category (check one)

M Full Membership Dues—$244.00

❏ Employed - Full Time

❏ Employed - Part Time

R Reduced Membership Dues—$122.00

❏ Not Employed

❏ Full Time Student

❏ New graduate from basic nursing education program, within six months after graduation (first membership year only)

❏ 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues—$61.00

❏ 62 years of age or over and not employed

❏ Totally disabled

Please Note: $5.42 of the CMA member dues is for subscription to The American Journal of Nursing. Various amounts are for subscriptions to CMA/DNA newsletters. Please check with your CMA office for exact amount.

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MEMBERSHIP APPLICATION

BY SUBMITTING THIS FORM, I HEREBY AGREE TO BE BOUND BY THE MEMBERSHIP APPLICATION AND MEMBERSHIP RULES OF THE VNA. ALL MEMBERSHIP APPLICATIONS WILL BE GRANTED SUBJECT TO THE MEMBERSHIP RULES OF THIS ASSOCIATION AND AMERICAN NURSES ASSOCIATION (ANA). YOUR APPLICATION WILL BE REVIEWED BY THE VNCTO BOARD. THIS APPLICATION MUST BE COMPLETED AND POSTED TO THE VNCTO BOARD BY MARCH 15TH FOR THE NEXT MEMBERSHIP YEAR.