The nursing shortage continued to be the major message from the Virginia Nurses Association to state legislators during the 2008 General Assembly. At the same time, we held out little hope for success given the current budget shortfall. We all know the biggest problem causing insufficient nurses is lack of educational capacity, and that nursing schools in Virginia and across the country turn away nearly as many qualified applicants as they are able to accept.

During the preceding legislative session, VNA, with help from many other nursing groups, was able to obtain more than $35.7 million to increase public nursing faculty salaries by ten percent. Unfortunately, this action put private schools of nursing that graduate more than a third of new nursing graduates at a competitive disadvantage in faculty recruitment. Therefore, we began talking with legislators about the need to appropriate some funds for private school faculty increases. The budget shortfall meant that the General Assembly was unlikely to fund any programs perceived as “new” and that would require continued funding. Nonetheless, we were able to continue to get our message about the nursing shortage, the major reason for the nursing shortage, and to educate more legislators about what this shortage means for quality and safety of care in the future. So, we continue to lay good groundwork for when the economic climate improves. The budget shortfall meant that the General Assembly was unlikely to fund any programs perceived as “new” and that would require continued funding.

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Acts of Courage

As I write this column, spring is upon us. The buds and bulbs are blooming and Virginia takes on the characteristic colors of the Bradford Pear, Dogwoods, Red Buds and Azaleas. It is truly a magical time of the year as we emerge from the doldrums of winter. Spring is a busy time for the Virginia Nurses Association as we prepare for the Week of the Nurse, and for hosting a meeting (the second of what we hope will be an annual gathering) of nurse specialty organizations on May 14. And with spring follows the graduations of nursing students from programs across the Commonwealth.

This is also the time of year that the VNA nominating committee begins working to identify qualified members to run for VNA office. In thinking about my own tenure on the VNA board, and my path to two terms as VNA President, I am reminded of a favorite quote by Anais Nin: “Life shrinks or expands in proportion to one’s courage.” Seeking a leadership position in your professional association is, in many ways, an act of courage. Rarely do any of us feel qualified or ready to assume a role with responsibilities and time commitments. Often, leadership positions require that we stretch ourselves, beyond our comfort zone in order to make contributions and to make a difference. Sometimes some members will complain about how poorly they think things are being done. It takes courage to choose to be part of a solution or progress, rather than to passively observe or make judgments.

Serving on the VNA Board is an excellent opportunity to expand your horizons in professional nursing. As a Board member you meet new people from across the state. You deliberate, discuss and debate issues of importance to nursing and you help shape the direction of the Association. It can be a remarkably enriching experience. I invite all VNA members to seriously consider running for office. The Association and the profession needs talent and energy to build on the accomplishments of the last several years. There is still much to do. Check out the VNA website (www.virginianurses.com) and this issue of the VNT for a list of available offices and duties. Be courageous and consider nominating yourself or a colleague for a Board or District level leadership position.

In keeping with the quote on courage, this issue of the VNT contains pertinent information on the topic of whistleblowing. The Professional Ethical Issues section of VNA’s Workplace Advocacy Guide for Nurses, also contains additional information specific for nurses in Virginia. According to the ANA position statement, whistleblowing is the public disclosure of unlawful or hazardous activities or practices by members of one’s own organization. This often occurs after employees have exhausted all other avenues to correct the problem. In whistle-blowing cases, nurses or other healthcare providers may be terminated for one of three distinct reasons: 1) for speaking out against unsafe practices 2) for violations of federal laws or 3) for filing lawsuits against their employers. Legal experts say the number of whistleblower cases in the healthcare field has been on the rise since 1999, when the Institute of Medicine reported that medical errors are the nation’s leading cause of death and injury. Despite the movement toward “no blame” cultures in the interest of quality improvement and error prevention, nurses and other healthcare professionals find themselves in a position to blow the whistle on unsafe practices. Whistleblowing by nurses usually results from concern about issues that jeopardize the health or safety of patients, or place the employee at risk due to occupational safety and health violations.

To minimize or eliminate the need for whistleblowing, healthcare organizations must establish an effective ethical climate that clearly articulates the priorities of the organization, as well as a defined procedure for resolving problems, including ethical disputes or conflicts.

It takes courage and conviction for professionals to decide to “blow the whistle” in their organizations. Whistleblower laws are in place in many states, to protect workers who chose to speak out, from retaliation by their employer. However, it is essential for nurses to understand the specifics of the laws so that they fully comprehend the extent and limits of legal protection. The risk of employer retaliation is a strong deterrent. Retaliation can be in the form of being ostracized by co-workers, or being dismissed from their jobs. Lengthy trials and legal expenses may result.

It is an important and courageous act to speak out when patient care and/or patient safety are compromised. The stakes for the employee get higher if the employer is not responsive to employee, or there are no mechanisms in place to address the issues. Nurses need to understand their rights and the law in their state, when making this important decision. ◆

President’s Message

The opinions contained herein are those of the individual authors and do not necessarily reflect the official position of the Association.

Virginia Nurses Today reserves the right to edit all materials to its style and space requirements and to clarify presentations.

VNA Mission Statement

The mission of the VNA is to promote education, advocacy and mentoring for registered nurses to advance professional practice and influence the delivery of quality care.

BOARD OF DIRECTORS:

Terri Haller, President; Shirley Gibson, President-Elect; Louise Hileman, Vice President; Ronette Langhorne, Secretary; Elizabeth Wolkenberg, Treasurer; Carol Cutler, CODP Chairman; Joe Tiell, CODP Representative to the Board; Esther Condon, Committee on Ethics & Human Rights; Sandra Olanitori, Commissioner on Nursing Practice; Sallie Eissler, Commissioner on Government Relations; Pam DeGuzman, Commissioner on Resources & Policies; Jeanie Matthews, Commissioner on Nursing Education; Terri Gaughy, Commissioner on WorkForce Issues; Lindsey Jones Cardwell, Director-Large, Jarvis Duffek, Social VNA Representative; Lorna Fetcue, President, Virginia Nurses Foundation.

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Susan Molley, Executive Director
Kathryn Mahone, Administrative Assistant
Tina DeGuzman, Continuing Education Coordinator
Bonnie Gilbert, Membership Coordinator
Celine Barefoot, Office Assistant

VNA Members:

Lindsey Jones Cardwell, Director-Large, Jarvis Duffek, Social VNA Representative; Lorna Fetcue, President, Virginia Nurses Foundation.
The 2008 VA General Assembly...

Two bills were introduced to license freestanding birthing centers. This initiative stemmed from 2007 General Assembly action that funded two birthing centers in Virginia where obstetrical care is sadly lacking. For these centers to get Medicaid reimbursement, they need licensure. Both bills were stricken at the request of the patrons to allow another year to work on the concept. They were HB-530 introduced by Del. Brenda Pogge (R-Yorktown) and SB-204 introduced by Sen. Fred Quyale (R-Chesapeake).

Del. Anne Crockett-Stark (R-Wytheville) introduced two measures to make nursing services more available in schools. Both failed in the House Appropriations Committee, largely because of lack of necessary funding. HB-569 would have required each school board to employ at least one experienced R.N. to supervise the nursing services provided throughout the school division. HB-570 would have required local school boards to employ one licensed nurse for each school building with no more than 750 students per nurse.

Del. Vivian Watts (D-Accomack) again introduced her bill to set safe staffing levels for nursing homes. This year, HB-1046, if passed, would have required the Board of Health to establish these standards. The bill was defeated in the House Appropriations Committee, largely because of funding. The Virginia Nurses Association, however, will be convening a safe staffing task force to look at options for ensuring safe staffing for both patients and staff in healthcare organizations. If you are interested in participating in this task force, or in providing information to it, please get in touch with the VNA office.

Access to Health Care Issues

For many years, nurses have been frustrated by a lack of access to appropriate healthcare for Virginians who make too much to be eligible for Medicaid but not enough to be able to afford healthcare coverage. Thus, they have supported every opportunity to expand care to these Virginians who cannot afford it.

As a result of the passage of SB-578, the VirginiaShare Health Insurance Program will be created. This program will provide health insurance premium assistance to allow eligible low-income working individuals to purchase health insurance coverage through a certified VaShare Health Insurance Policy.

For some years, the law has included provisions for the re-use of dispensed but unused drugs by hospitals and nursing homes for the use by free clinic patients. This law has not resulted in many available drugs. In an attempt to make it more workable and productive, Del. Steve Landes (R-Western) introduced HB-85. This measure passed.

A companion bill introduced by Del. Landes, HB-86, would have created an unused pharmaceutical disposal program. This measure would have provided for the safe, effective and proper use of unused pharmaceuticals. This bill was carried over to the 2009 session for further consideration and possible modification.

Sometimes, legislation seeks to restrict access to care. Such was the case with HB-121 introduced by Del. Scott Lingomfelter (R-Prince William) that would have required mental health providers employed by local governments, Community Service Boards or Behavioral Health Authorities to report to the minister’s parent that he had sought mental healthcare. Under current law, in most cases a minor can consent to mental health and substance abuse treatment, as well as such things as pregnancy testing and diagnosis and treatment of STDs. This is a crucial component of access to care since adolescents may not want their parents to know about their problems. This bill failed to pass when the Senate Committee heard testimony that mental health treatment plans for minors almost always include family involvement early in care, and that almost all minor’s tell their parents about the treatment and choose to involve them.

Del Brian Moran (D-Alexandria) introduced HB-1190 that would have required certain measures designed to lower the infant mortality rate in the Commonwealth. These measures would have included expanding FAMIS eligibility for pregnant women with an income level up to 200 percent of the federal poverty level, providing coverage for one year postpartum; prohibiting the state from charging copayments for prenatal services for state employees; and (v) requiring the Commissioner of Health to launch a public education campaign aimed at preventing Sudden Infant Death Syndrome. This measure failed in the House Appropriations Committee despite the high infant mortality rate in the Commonwealth.

HB-1227 introduced by Del. Margie Vanderbyre (D-McLean) directed the Virginia Department of Health (VDH) to expand access to breast and cervical cancer screening available under the Every Woman’s Life Program. Since this bill had a fiscal impact, it was referred to the House Appropriations Committee where it failed to pass.

Health Care Issues

Sen. Janet Howell (D-Reston) introduced SB-63 and Del. John O’Bannon (R-Henrico) introduced HB-246 to require the State Board of Education to develop a database for nutrition and physical activities best practices in schools. Both bills passed and will become law, although no school division will be required to submit information or follow any of the best practices.

Del. Bob Marshall (R-Prince William) sought to remove the requirement that girls have an immunization for human papilloma virus before they enter sixth grade. We now know that this virus is a primary cause of cervical cancer, so the bill that created this law in the 2007 session was passed with thoughtfulness and concern by the legislators. Thus, the 2008 General Assembly declined to repeal the requirements.

Del. Marshall also introduced HB-188 that sought to delay this requirement from 2008 to 2010. The General Assembly also failed to agree to this change.

(continued on page 4)
EXECUTIVE DIRECTOR’S COMMUNIQUÉ

It’s spring! What a perfect time to regroup, get organized, and put your calendar together for the rest of 2008. There are exciting things going on with nursing and in this issue, VNA’s government relations specialist, Leslie Herdegen Rohr, has given you an in depth recap of the 2008 General Assembly Session. As you can see, there is no time to rest! We are already looking ahead to next year, so please make sure you are getting the public policy emails and your VNA member emails. Visit www.virginianurses.com to make sure you are up on the latest issues.

Exciting news! As you know from the Richmond Times Dispatch supplement for the week of the Nurse, or if you attended the Nursing Roundtable at VCU School of Nursing, Virginia is getting a Healthcare Workforce Data Center. Sandra Whitley Ryals, Director, Virginia Department of Health Professionals, announced that the Governor’s Discretionary Fund under the Workforce Reinvestment Act awarded $275,000 to establish the Governor’s Discretionary Fund under the Workforce Reinvestment Act awarded $275,000 to establish the Virginia Nurses Foundation Gala celebrating excellence in nursing. Details to follow in our next issue and on the website at www.virginianurses.com.

General Assembly Session. As you all know, one of the critical components of the nursing shortage is the lack of education capacity that causes qualified students to get turned away from nursing schools in Virginia each year. We are pleased to announce that under the leadership of Marilyn B. Taverner, Secretary of Health and Human Resources, Virginia applied for a competitive slot for a national education summit. Virginia was one of fourteen states to be accepted to this summit that will take a look at best practices for expanding educational capacity by sharing best practices, innovation, and developing a strategy for Virginia.

Please help the association continue to support this great work being done on behalf of nursing in Virginia by joining the association today. Visit www.virginianurses.com for membership information and an application. For the cost of a little over twenty dollars a month, you can help move nursing forward and assure that the future health care needs of Virginia’s citizens are met. There has never been a better time to be a member of VNA!

Save the date! Plan to join us at the Richmond Marriott on Saturday, October 25 for VNA’s education day: The Staffing Imperative. Gain nursing continuing education, networking, and practical knowledge for dealing with the number one nursing issue in Virginia. Plan to stay the evening for the Virginia Nurses Foundation Gala celebrating excellence in nursing. Details to follow in our next issue and on the website at www.virginianurses.com.

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Study Resolutions

Many resolutions related to healthcare were introduced, but almost none of them passed. One that did was HJR-79 introduced by Del Phil Hamilton (R/Newport News) that requests the Governor and the Secretary of Health and Human Resources to develop a policy barring physicians or other healthcare practitioners from prescribing an alternative brand of medication because of financial incentives without first disclosing the incentives to the patient.

A study that was of particular interest to nurses was introduced by Del. Kris Amundson (D-Mount Vernon) as HJR-207 and by Sen. Edd Houck (D-Prince William) as SJR-128 at the request of the AARP and with the support of the VNA. Both measures failed in the House Rules Committee. These resolutions would have asked the Joint Commission on Health Care to determine whether the licensure boards for health professionals should require evidence of continued competence at the time of relicensure, and if so, what those requirements should look like. VNA supports requirements to demonstrate continued competence, but believes this demonstration should include options other than just continuing education requirements. Conversations between nurses and the AARP will continue over the interim before the next session.

For More Information

More information on any of these bills, or any other bill related to nursing, healthcare, or safety, can be accessed on the Virginia Nurses Association’s government relations page found at www.virginianurses.com.
reimbursement for nursing home and many other service providers. Daily reimbursement for Medicaid residents in nursing homes is less than the actual cost of providing quality care we all would like to see. This is not a problem in nursing homes that have staffing ratios that reflect the true great need for nursing homes with a high percentage of Medicaid patients. VNA has worked to negotiate competitive reimbursements for nursing home residents to begin to overcome this problem.

2. Patient care unit. We have solid data on the shortage of RNs in Virginia and the projected worsening of this shortage. While we do not have data on shortages of LPNs and CNAs, we can assume the same or similar conditions exist in these professions. It is illogical to mandate staffing levels if professionals are not available to fill the required positions. This could result in bed closings and unavailability of nursing home services. VNA, along with legislators, saw this as causing greater harm than inadequate staffing. VNA has worked to ensure that there are more RNs available in Virginia, and that all nursing facilities make the LPN and CNA supply and demand to determine whether action is needed in these areas, too.

3. Concern: not floors. The concern that is raising VNA's is that staffing requirements often become ceilings rather than floors. While staffing requirements are set to set a minimum level of staff, or staff contact hours with patients or residents, they can also provide incentives for facilities with higher staffing levels to staff down to the minimum to save money. This would be particularly possible in nursing homes with many private pay residents. Inadequate staffing ratios and contact hours with patients and residents in these facilities. The result of staffing requirements is that they would decrease levels of staff and quality of care in some licensed healthcare facilities.

At the same time, VNA continues to receive communication from nurses working in licensed healthcare facilities with RN-to-patient ratios that far exceed what the research shows to be necessary to prevent adverse events, morbidity and mortality of patients. And, we know that nurses working under these suboptimal conditions face higher levels of job dissatisfaction, which is likely to result in higher nurse turnover rates. More nurses leaving direct care, or leaving the profession altogether, worsening the nursing shortage. Maybe the time has come for VNA to revisit its position. Staffing plans that are based on that consideration, we reviewed the nine other states and the District of Columbia have addressed these concerns.

Staffing Plans

Between 2002 and 2007, Texas, Rhode Island, Oregon and Illinois have enacted legislation or adopted regulations that require hospitals or all licensed healthcare facilities to develop, implement and enforce staffing plans that are based on the number and types of nurses on each unit on each shift and the average number of patients on each shift in each unit. The staffing plans are to be developed with some input from direct care staff nurses, either in an advisory or decision-making capacity.

In most cases, these staffing plans must be consistent with national research, standards adopted by the state licensing board, specialty standards, and guidelines recommended by the American Nurses Association. The General Assembly may find a fiscal impact and, as a result, kill the bill in this budget shortfallover year. In 2002, Virginia ANA has tried to work with residents and staff in some nursing homes that have truly inadequate staffing and care levels, until now, we have shared the two major concerns of nurses and have one other concern. Those concerns are:

1. The level of Medicaid reimbursement. Virginia has one of the lowest levels of Medicaid reimbursement for nursing home and many other service providers.

2. The level of Medicaid reimbursement for Medicare residents in nursing homes is less than the actual cost of providing quality care we all would like to see. This is not a problem in nursing homes that have staffing ratios that reflect the true great need for nursing homes with a high percentage of Medicaid patients. VNA has worked to negotiate competitive reimbursements for nursing home residents to begin to overcome this problem.

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The Future in Virginia

Perhaps the time has come for the Virginia Nurses Association to explore the current staffing situations in Virginia, note any that appear to compromise patient care, and decide how to rectify those situations. To make that determination, however, we need to hear from nurses working on the ground about what their staffing concerns are, and from those who work in facilities that are doing it right.

We have nine magnet hospitals in Virginia. A magnet hospital is a hospital where nurses delivering excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate, and appropriate grievance resolution. Magnet status also indicates nursing involvement in data collection and decision-making and a culture of collaboration and accountability. Magnet hospitals place a high value on nurses and the difference they make in safe and quality care.

We know our colleagues, the nurse executives, share your concerns about nurse staffing, and we should hear from and work with them as we decide whether and how to move forward. We should develop a plan that helps every patient care to Virginia in the future.
To Blow the Whistle...or Not

by Leslie Herdegen Rohr, VNA Government Relations Representative

Cynthia Cooper. Colleen Rowley. Sherron Watkins. Who are these women? Only the most serious news junkies will remember these accomplished but otherwise ordinary women whose names made news on February 9, 2001, when giant Worldcom, then the seventh largest U.S. company, was declared “The Year of the Whistleblower.” These women made hard choices when they went public with wrongdoing at Wordcom, the FBI, and Enron respectively. Their actions were the right thing to do, resulted in justice, and changed their lives forever.

From elementary school on, we are taught by our peers that tattling is one of the worst sins that can be committed. Yet, during this century, whistleblowing has become an admired quality. What has made the difference? Perhaps there is a sense that organizations, particularly big businesses, have so much power that they are able to take advantage of ordinary Americans and literally ruin their lives. No longer do employees work for the same corporation their entire lives— the corporations do not seem to have the same loyalty to their employees, and the employees do not seem to have the same loyalties to their employers. Of course, there are exceptions to this, but they are the exception rather than the rule...

Or, perhaps it is that as young children, we are unable to recognize that our primary loyalties can and should be overridden by compelling moral reasons. This distinction that, even as adults, we have trouble making.

What is Whistleblowing?

While some define whistleblowing broadly, most make a distinction between “reporting” and “whistleblowing.” Reporting recognizes that most healthcare organizations have an internal process for sharing employee concerns in an environment that allows them to be addressed within the organization. Whistleblowing, on the other hand, is construed as an external action to an organization that has not responded appropriately to a concern expressed by an interested party. Many whistleblower laws require that internal reporting mechanisms be utilized first. Even if the law does not, this is a good and ethical standard to follow.

Whistleblower Laws

Whistleblower laws have been passed at the state and federal level to allow employees to stop, report or testify about employer actions which are illegal, unhealthy, or violate specific public policies by prohibiting retaliation against whistleblowers. There are more than fifty federal whistleblower laws. Some of them relate directly to healthcare organizations. Others are broader and include employees in many industries. Many are administered by the Federal Department of Labor; others are administered by other federal agencies. Some have statutes of limitations of as little as ten days; others are much longer. Some have administrative remedies; some allow for civil remedies; and still others provide no remedy at all to an employee who alleges retaliation as a result of his whistleblowing activity. Entire books have been written and published on federal whistleblower statutory laws and case law. It is not within the scope of this article to review these laws. Instead, it will focus on Virginia laws that prohibit retaliation against whistleblowers in certain healthcare settings and some things you might want to consider before you make a decision to blow the whistle.

Virginia’s Health Care Whistleblower Protections

Virginia has three laws that protect complainants against retaliation or discrimination in hospitals (Va. Code § 32.1-125.4), nursing facilities (Va. Code § 32.1-138.4) and assisted living facilities (Va. Code § 32.1-1730). By utilizing the term “complainants,” these laws apply not only to employees, but also to volunteers, patients, residents, families, and others who have an interest in the rights of patients or residents in hospitals, nursing facilities, or assisted living facilities.

While this sounds clear and easy, in practice, it often is not. First, there are no standards embodied in these laws. There are no standards embodied in these laws that may be used as a violation of patient rights may not be seen by others in a similar fashion. Furthermore, there is no specified remedy. Healthcare organizations that retaliate under these circumstances, so any remedy by an employee will be in civil court, often a protracted and costly proceeding.

Thus, it may be helpful to look at what others say about the protection of patient rights before relying on these laws exclusively.

What JCAHO Says

While the Joint Commission on the Accreditation of Healthcare Organizations does not specifically require due process and other protections for staff members who intervene on behalf of patients, they are required to have “structures to support patient rights...in a collaborative manner that involves the hospital’s leaders and others.” JCAHO also requires healthcare organizations to have mission statements and a patient bill of rights that reflect the organization’s basic beliefs. So, while JCAHO does not require structure to encourage internal reporting or prohibit retaliation against an employee who goes public with an unresolved concern, in some cases, these may be extrapolated from JCAHO requirements.

You will want to note that many assisted living facilities are not subject to JCAHO requirements.

What the ANA Code for Nurses Says

While the Code for Nurses does not specifically state when values should be upheld and what responsibility RNs have for reporting internally or externally specific situations, Provision 6 of the ANA Code for Nurses requires RNs to participate in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.

This and other provisions of the Code when read as a whole, should give nurses some guidance as to their role as a healthcare professional in reporting and helping to correct unsafe, inappropriate, or negligent practices. You can read the entire Code at http://nursingworld.org/ethics/code/protected_whistleblowers.htm.

Other Considerations

While internal whistleblowing (as well as internal reporting) can have serious consequences for the nurse and the organization, it is not an action that you will want to take lightly. At some time in your life, you will want to report or blow the whistle can be life-threatening for patients as well as staff. Here are some additional considerations you will want to weigh as you decide how to proceed:

• Do your concerns represent a substantial risk to patient or staff safety, healthcare outcomes, or morbidity or mortality?
• Are your concerns the result of a single event, or a pattern of practice?
• Have you fully investigated the situation, collected appropriate facts and other data, and thoroughly understand the situation as reported to you?
• Have you exhausted established internal processes before you think about making your report?
• Do you have a positive tenure and reputation within your organization or profession?
• Have you thought about the need for a legal defense and representation?

Note of Caution

reporting in inadequate conditions in healthcare organizations, and ultimately deciding to blow the whistle on those that are not corrected, is a complex area of state and federal law. Making a decision in this area also requires scrutiny of the ANA Code for Nurses and JCAHO requirements. And neither this article nor your personal judgment should be a substitute for good legal counsel or representation with experience in this area. So let your conscience be your guide as to whether you need to investigate your options more fully.

Save the Date

VNA’S 2008 DELEGATE ASSEMBLY WILL BE HELD ON FRIDAY, OCTOBER 24TH.

NEW THIS YEAR, A SATURDAY EDUCATION DAY, THE STAFFING IMPERATIVE—please plan to attend and stay for the evening’s GALA CELEBRATION OF NURSING EXCELLENCE TO BENEFIT THE VIRGINIA NURSES FOUNDATION. For details, visit www.virginianurses.com
When the State Board Calls: Part II
Interview with Jay Douglas R.N., M.S.M., C.S.A.C.
Executive Director, Virginia Board of Nursing
Mary Ann Frierson RN,CNS, MSN, RN, CRNI

This is the second article of a two-part series by the Center for American Nurses written to address an issue related to the State Board of Nursing. The first article in this series presented the perspective of Lorraine Utzner Wright, R.D.N., B.S.N., J.D. (December 2007), who provides legal services such as defending nurses in licensure matters. The second part of the series offers the perspective of an Executive Director of a Board of Nursing.

The Board of Nursing exists primarily to protect the public. Each state has processes that regulate the practice of nursing. The Board of Nursing is responsible for establishing rules and regulations that govern professional practice. In order to more clearly understand current issues related to the regulation of nursing practice, the Center conducted an interview with Jay Douglas, R.N., M.S.M., C.S.A.C., Executive Director of the Virginia Board of Nursing, who provided an overview of the role of the Board of Nursing and discussed current issues regarding the regulation of nursing practice.

Although state jurisdictions vary in terms of their rules and regulations, usually a process is in place for following up and addressing complaints against nurses. The process for one state is presented as an illustration of the process.

The Center: One of the responsibilities of the Board is to protect the public and investigate complaints against nurses. Could you describe the investigation process?

Ms. Douglas: In the state of Virginia, all complaints are received by the Department of Health Professions—Intake Unit. Complaints are reviewed by a Case Analysis Reviewer, who determines whether the Board has jurisdiction over the complaint filed against a nurse. Many of the complaints made against nurses do fall within the jurisdiction of the Board, but not violations of law and regulation. For example, if a complaint is filed that a nurse defrauded on health care, this is outside the scope of the Board and would not be investigated by the Virginia Board of Nursing. If the complaint is outside the jurisdiction of the Board, it may be referred to the appropriate jurisdiction or authority. If it is determined that a possible violation of statute or regulations governing nursing practice has occurred, a case is opened and is referred to an investigator. Cases that pose the greatest threat to the public are given priority. Once a case has been opened, the investigator may interview persons who have knowledge of the event and review relevant records, including medical and personnel records. The investigator summarizes all relevant findings and evidence in a report, which is forwarded to the Board.

The Board then reviews the report, and if there is insufficient evidence to indicate that a violation has occurred, the case is closed. However, if there is evidence of a violation, the Board may meet with the reported nurse or may offer a plan to resolve the matter. The outcome of the administration proceeding may involve the following:
- Closing the case with no violation
- Sanctioning the nurse
- Referring the case to the full Board of Nursing for review

A formal Board hearing may be conducted for the following reasons:
- The reported nurse requests a hearing
- The conference committee recommends a hearing

Disciplinary actions range from a reprimand or censure to suspension of a license; other disciplinary actions include fines or civil penalties, named corrective action, prohibition, limitation or restriction of practice, and suspension or revocation of license. The Board is required to report certain licensing actions to the National Practitioner Data Bank.

The Center: With the evolution of technology, nurses may be licensed in one state and may respond to a situation from a patient in another state, or they may provide nursing intervention telephonically to a patient in another state. How is regulation of the nurse’s practice governed in this situation?

Ms. Douglas: The nurse who provides professional nursing care must check with the Board of Nursing in the state in which nursing care is being rendered. Typically, a license is required to provide nursing care in a state or in which the patient is located, even if the nurse’s license is located in a different state. In Virginia, the Board of Nursing provides a list of reciprocal states. A nurse who is licensed in a reciprocal state is providing care to a patient in a nonreciprocal state would be required to provide proof pursuant to the reciprocal license compact.

The Center: How frequently are complaints lodged against nurses?

Ms. Douglas: The number of complaints lodged against nurses is relatively low. For example, in the state of Virginia, 85,552 Registered Nurses and 22,259 Licensed Practical Nurses are practicing. Complaints filed over the last year totaled 1,115.

The Center: What advice do you have for nurses regarding the Nurse Practice Act?

Ms. Douglas: Upon acceptance of a nursing position in a particular state, review the Nurse Practice Act and become knowledgeable regarding the scope of practice for the state in which the nurse will be practicing. Nurse Practice Acts vary from state to state, and it is important for the nurse to comply with the rules and regulations for the state in which she or he is practicing. This is important for all nurses, even for those practicing in reciprocal states, because variations have been noted in the licensure rules and regulations among the compact states.

Nurses may not want to notify the Board of any changes in address. In the event a complaint is lodged against a nurse, the Board will need to notify the nurse. If the nurse has not notified the Board of any address change, the Board may not be able to contact the nurse, a complaint could be lodged, and an administrative proceeding may be scheduled without the nurse’s knowledge.

Additionally, the Board may have to send information to the nurse regarding license issues and other critical updates; if the nurse has not informed the Board of the current address, the nurse may not receive important communication from the Board.

Nurses may attend disciplinary proceedings and meetings of the Board because there are open to the public. Attendance at such meetings provides an opportunity for nurses to learn more about the Board’s role in promoting the public’s health.

References
Jay Douglas is the Executive Director of the Virginia Board of Nursing. In this position, the nurses licensing and discipline for more than 150,000 licenses and certificate holders, including Registered Nurses, Licensed Practical Nurses, Advanced Practice Nurses, Massage Therapists, Nursing Assistants, and Medication Aides. Before assuming her current position, Ms. Douglas served as Deputy Executive Director for discipline at the Board of Nursing for three and one-half years, immediately before becoming her work with the Board of Nursing. Ms. Douglas served in a variety of roles, including Administrator for Multiservice Home Care from 1994 to 1999. Jay is a Registered Nurse with a Master’s Degree in Management, and the India Certification in Addiction Counseling.

This “Nursing That Works” article is not intended to take the place of any professional legal advice. For more information, please contact your State Board of Nursing or state nurse’s association, or get in touch with a licensed attorney in the state in which you are licensed.
Is your organization currently in the midst of making changes? Are you looking for ideas to improve your process while increasing employee satisfaction and retention? If you are ready to discover new ways to maximize your organization’s productivity and efficiency, then all you need to do is ask the right questions.

Appreciative Inquiry allows you to do just that.

So what is Appreciative Inquiry? It’s a verbal science that’s been around since the 1980’s, that shows us how to ask questions in a way that will elicit positive responses. By using this model you can gain a fresh new perspective and spur positive change within your organization. The reality is that wonderful things can begin to happen when you stop focusing on the negative and start focusing on the positive.

Why is this new method of gathering information effective? Because, it’s different than how we’ve done things in the past. Because most people think thoughts that are 70-90 percent negative or of no use to them, it’s very easy to understand why we tend to ask questions that focus on what’s wrong, rather than asking questions that focus on what’s right.

We ask “who made the mistake,” rather than asking “What actions do we have to fix things?” We ask “who can be blamed for this,” rather than asking “what did we learn from this?” Or, we ask, “what’s wrong with this picture,” rather than asking, “What am I doing right?” In short, in the past we had a “what was I thinking,” or “what were they thinking,” mentality.

So who invented Appreciative Inquiry? Two professors, David Cooperrider and Suresh Srivastva, at the Weatherhead School of Management at Case Western Reserve University. To date, hundreds of people have been involved in co-creating new concepts and practices for applying the spirit and methodology of Appreciative Inquiry into organizations all over the world.

The Appreciative Inquiry Process consists of a 4-D cycle: Discover, Dream, Design and Destiny.

By using these four steps, you too can begin to use this positive process to grow your organization.

Discover: The first step in the Appreciative Inquiry cycle focuses on identifying “what is.” To uncover the current situation, you will begin by asking carefully constructed positive-focused questions. Here, among other things, your goal is to discover what drives success, contributes to employee satisfaction, and helps maximize productivity. The purpose of the questions asked during this stage in the process is to discover how the organization is most alive and successful. The goal here is to create an open-dialogue where information flows freely. Here is a sample of questions designed to help you illicit positive responses during the discovery stage:

Share a time with me where you felt the happiest/most successful at your job? What first attracted you to this job? Tell me about a time when you felt reassured? What three things have you liked most about your time here thus far? What do you value most about the nature of your work? Tell me about a time where you felt your organization was most connected to its patients? What do you think draws people to work here? If you could talk to the President of the organization, what is the one thing he/she could do to make your job better, faster, or more enjoyable? If you could fast-forward three to five years into the future here thus far?

Dream: After identifying the current situation or “what is,” the next step in the Appreciative Inquiry process allows you to focus on “what might be.” Here are some positive-focused questions that will help you to navigate this stage:

Imagine and tell me what your perfect shift would look like? What are your deepest desires for the organization? If you could wave a magic wand and have exactly what you desire, what would that be? If a genie granted you three wishes pertaining to your job or organization, what would you ask for? If you could fast-forward three to five years into the future and imagine that your highest hopes and dreams for your organization have become a reality, how does the organization look? How is your work or day different? What are some of the ways that you’re interacting with others in the organization that are working for you? During the Dream step, the possibilities are endless. Give yourself and members of your organization the gift of no boundaries in order to dream your biggest dreams.

Design: Once you’ve discovered strengths and possibilities in the last two stages, you’ll want to find ways to achieve these dreams. So now that you’ve discovered “what might be,” your job in the Design phase is to discover “how can it be.” Here, you’ll generate “possibility statements,” also termed “provocative propositions.” Possibility statements are designed to stretch the status quo, be grounded in the organization’s history, and, most importantly these statements focus on the desired future. The result of this stage is that you will have a series of paragraphs that outline how the Dream will be realized. The big question to ask at this state is “how can we go about achieving what we envisioned in the Dream phase?”

Destiny: Now, that you have generated a list of possibility statements, its time to make your dreams a reality. This step focuses on “what will be.” At this point in the process, you will choose what you will move forward with. You will begin to incorporate the possibility statements with your job, your team, and your organization. Here you’ll find ways to apply overall Appreciative Inquiry process to your overall culture. Destiny is not an end to the process, but the beginning to a whole new way of doing business.

Appreciative Inquiry just makes sense when you stop to think about it. People tend to gravitate in the direction in which they are focused on the most. Therefore when you focus on the negative, your problems will just get bigger and more overwhelming. However, by giving yourself and your organization the gift of Appreciative Inquiry, you will focus on the positive and begin to be awed by the differences it can make. Remember, small changes to questions you may already be asking or small changes to your current outlook will help you ignite positive change.

Dr. Susanne Gaddis, PhD, known as The Communications Doctor, is an international professional speaker, communications consultant, and executive coach. Workshop leader, Cara Williams, M.A., offers courses in appreciative inquiry, positive organizational development and emotional intelligence. To Contact Cara or Susanne, call 919-933-3237 or e-mail: gaddis@communicationstdor.com.
It is Spring… and finally it is time to be GREEN. As one comes out of Winter, it seems so long since there was green.

A commitment for each nurse, and for those charged with the healthiest environments with a focus on conservation. There is no mystery, Joanne added advocating for Healthy Work Environments (HWE) and to be environmentally conscious—to reduce the carbon footprint in one’s life both at home and at work. There are similarities and parallels with these two causes; nurses can promote both simultaneously. The environmental aspect of the Nightingale’s life is rooted in history and projects far into the future.

Nightingale promoted health through the careful control of the environment. Despite bad sanitation, bad architectural [design and elements], and bad administrative arrangements (p. 8, 1860). For the environment, Nightingale demanded there be excellent ventilation (pure air and air flow), pure water, efficient drainage (sanitation, i.e., proper handling of body substances), cleanliness, natural light, proper shading to protect from sunlight, and noise control. She spoke to two settings of care, the home and the hospital. And nurses should do the same today for their living environment at home and in the practice setting.

Nurses live in their workspaces—or so it seems by the work they care for patients. Their work environments matter for the staff and for the patients. We are gaining awareness of the chemicals in the environment, we are gaining knowledge of the effects of these chemicals. Many chemicals are not inert, for once these have entered the body, the chemicals reside long-term adding to a toxic body burden that increases genetic mutations and promotes cancer development.

In 1995, the Institute of Medicine (IOM) published information of a very different kind for patients. Their work environments matter for the staff and for the patients. We are gaining awareness of the chemicals in the environment, we are gaining knowledge of the effects of these chemicals. Many chemicals are not inert, for once these have entered the body, the chemicals reside long-term adding to a toxic body burden that increases genetic mutations and promotes cancer development.

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What is Faith Community Nursing? Commonly called parish nursing, this professional specialty practice recognized by the American Nurses Association since 1997 focuses on whole-person health; that is, care of the body, mind and spirit, with particular emphasis on spiritual well-being. The integration of faith and health is the essence of this unique and wonderful nursing practice. The Standards and Scope of Parish Nursing was published by the ANA in 1998. The registered professional nurse working in this ministry must work according to the nurse practice act of the state in which she/he is practicing, and comply with the identified standards of practice.

Developed by Lutheran minister, Dr. Granger Westberg in the early 1970’s, parish nursing offers a professional nurse ways to provide special health promotion services within a given faith community. Dr. Westberg recognized the church has promoted health and wholeness for centuries through worship, music, sharing and caring, and that it is the only human institution in our society that interacts with individuals from birth through death. The faith community/parish nurse extends this historical role of the church and synagogue in the promotion of health and wellness. A Faith Community Nurse (FCN) is the visible presence of an intentional health ministry, complementing the work of the clergy and ministerial team. The FCN is a registered nurse who has had additional educational preparation in wholistic ministry. Most nurses aren’t familiar with the theological perspectives on health and healing, or with working in a congregation. Preparation for the role is through attendance at a basic education program that uses a standardized core curriculum. The curriculum was developed through the International Parish Nurse Resource Center (IPNRC) by 35 parish nurse experts from across the country. In Virginia, the course is offered annually at Shenandoah University, in Winchester. Martha Erbach, RN, MEd, MSN has led the SU course for nearly 15 years, and was contributor in developing the 2004 revision of the IPNRC’s core curriculum. On-line parish nurse courses exist, but as an attendee of the Shenandoah University program, I cannot imagine forfeiting the spiritual enrichment that comes through fellowship with other participants in a class format that includes worship and reflection.

Education on faith community nursing practice is ongoing, and the development of a sound health ministry within a congregation requires recognition that it takes time and careful planning. It is important (and sometimes challenging) to establish an appropriate understanding that the parish nurse’s care of the ‘whole person’ includes other than the provision of physical care. A Faith Community Nurse does NOT provide hands-on care; rather she/he makes referrals to home health or other community agencies to provide direct care. Optimal mental, physical and spiritual health is promoted by the FCN who performs/coordinates different services based upon the congregation’s needs. The seven primary functions of the FCN include integrator of faith and health, health educator, personal health counselor, referral agent, trainer of volunteers, developer of support groups, and health advocate.

Registered nurses working in an acute care setting will find the faith community nurse course beneficial for gaining increased knowledge and understanding of spiritual care. JCAHO requirements include addressing our patients’ spiritual needs, but those in Parish Nursing know that the need for care of the spirit is everywhere. ◆

Note: The 2008 Interfaith Basic Educational Preparation in Faith Community Nursing at Shenandoah University takes place April 16-19 and May 29-31. Interested RNs may contact Reen Markland at 540/534-0542, rmarkland@valleyhealthlink.com or Martha Erbach at 540/665-5500, merbach@su.edu

This is my experience with two kidney stones. The first one happened when I was a driver for FedEx. It rattled around inside me for 13 weeks, finally driving me to the extreme measure of having it broken up by minimally invasive micro-surgery; performed in a hospital. It should be noted that access to the repair was gained through the groin/ureter. There was after-care to remove a stent which was used to keep the affected ureter open.

The second stone happened when I was no longer working and had no health insurance. I had exhausted everything in our medicine cabinet that could deal with the pain. If you have never had a stone, you don’t really know pain. My wife dug out one of our herb books and showed me a recipe from Heinerman’s Encyclopedia of Healing Herbs and Spices by John Heinerman. The tea is supposed to soothe irritated tissues and help break up or partially dissolve the stones, while the oil taken afterwards acts as a lubricant to remove them from the body more easily.

Preparation of this tea consists of boiling 4 cups of water and adding 2 tablespoons of chopped fresh or dried burdock root. This is then reduced, covered, and simmered for about 10 minutes. After which, this mixture is removed from the heat and 3 teaspoons of pure maple syrup or blackstrap molasses to sweeten, and drink slowly. Exactly 10 minutes later, consume 1 tablespoon pure virgin olive oil.

Instructions are to repeat this regimen 3 times each day. Importantly, it is recommended that no greasy, fried foods, soft drinks, refined carbohydrates (such as white flour or white sugar products), red meat or poultry be consumed during the treatment.

Based on my experience, this recipe for a burdock & catnip tea turned out to be a great remedy for getting rid of the stubborn kidney stone. I drank my cups of this tea, and collapsed into bed that evening, getting rid of the stubborn kidney stone. I drank my cups of this tea, and collapsed into bed that evening, still wracked with pain. The pain (and supposedly the stone) was gone in the morning. I know this proves nothing, but if you were to someday find me in the throes of a 3rd stone, insured or not, I’d be down by the ravine looking for some burdock. ◆

REFERENCES

The author offers this recommended reading: The Green Pharmacy (St. Martin’s Press, 1997) by James A. Duke, PhD.

Note: The author resides in Black Hammer Township in Southeastern Minnesota. This content is based on the author’s personal experience.
The Need To Go Green

by Theresa Gaffney, BSN, MPA, RN
Commissioner of Workforce Issues

Artificial Turf: Hazardous to Your Health?
Fox Business, April 18, 2008

Traces of Drugs in Drinking Water Prompts New Rules—National Post, Canada, April 18, 2008

Help Keep Drugs Out of Water supply—Lexington Minuteman, March 25, 2008

Hormonal Problems Might be Linked to Chemical in Plastic Bottles—USA Today, April 15, 2008

Nurses Chemical exposure Studied—The Journal Gazette, December 19, 2007

These are just a few of the media headlines we have been treated to during the past 4 months. In our homes, communities and workplaces we are exposed to a rapidly growing array of hazardous substances. Toxic chemicals in our workplaces can include cleaning chemicals, anesthetic gases, and medications while in our homes and communities we are exposed to high levels of radon, lead, and mercury.

Nurses understand the link between health and the environment and are well positioned to make a difference. On March 8, 2008, more than 40 nurses gathered to discuss strategies to become better stewards of the environment and create healthy healing healthcare environments for both nurses and patients.

According to the findings of the first ever national survey of nurses' exposures to chemicals, pharmaceuticals and radiation on the job, released in December 2007, by Health Care Without Harm (HCWH), there are links between serious health problems of nurses such as cancer, asthma, miscarriages and children's birth defects and the duration and intensity of exposures to hazardous substances. "Nurses ingest, touch or breathe residues of any number of these potentially harmful substances as they care for patients, day after day and face potential but unstudied health problems as a result," said Jane Houlihan, Vice President for Environmental Health Concerns and Toxic Chemicals in Healthcare Facilities, HCWH.

The newly created VNA Environmental Health Task Force will coordinate nursing's effort to develop and implement strategies to create ecologically sustainable environments in our homes and workplaces. Workshop participants offered priority areas of focus for the task force's inaugural efforts such as partnering with Schools of Nursing to offer environmental health education for students, exploring legislative/policy initiatives, promoting "green meetings" and establishing "green teams" in hospitals.

NURSE FATIGUE

Research indicates that nurse fatigue results in slowed reaction time, lapses of attention, errors of omission, and diminished problem-solving ability. A study by Anne Rogers, PhD, RN, FAAN, further indicates that medication administration and procedural errors are the most common types of errors reported by nurses as a result of fatigue. The Virginia Nurses Association (VNA) is actively involved in expanding the science in the area of nurse fatigue and its impact on patient safety and is excited to collaborate in a research study being conducted in the Grado Department of Industrial and Systems Engineering at Virginia Tech. This study will evaluate nurses' perceptions of their mental and physical performance. We invite you to participate by completing a short survey intended to measure nurses' perceptions about work environment, fatigue, and work performance. The survey can be found at http://www.virginianurses.com.

Want to learn more about environmental health? Check out these resources:

Body Burden—The Pollution in Newborns


Tox Town—Environmental health concerns and toxic chemicals where you live, work and play—http://toxtown.nlm.nih.gov/

The Luminary Project—Illuminating stories of nurses' activities to improve human health by improving the health of the environment. http://www.theluminaryproject.org/
New Patient Care Innovations in a Holistic Environment: The Planetree Model... featuring an interview with Linda Sharkey, MSN, RN

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

Linda Sharkey has worked in a variety of acute care settings as a hospital supervisor, nurse manager for reviewers of defense malpractice cases, assistant director and director. In 2003 she joined Fauquier Health System and is Vice President of Patient Care Services/Chief Nurse Executive. She currently serves on the boards of the Fauquier Free Clinic, Piedmont Home Care, and the American Organization for Nurse Executives. Ms. Sharkey received Inova Health System’s Manager of the Year and Innovation Nurse Executives. She currently serves on the board of the American Nurses Association’s Chief Nurse Executive. She currently serves as Vice President of Patient Care Services/Chief Nurse Executive. She currently serves on the board of the American Nurses Association’s Chief Nurse Executive.

We recently talked with Ms. Sharkey regarding the Planetree model and what nurses can do to implement changes that embrace the Planetree philosophy.

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

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

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

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

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

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

Center: What is your vision for nursing regarding the Planetree model?

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

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

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

The Jury Is In and the Verdict Is......

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Ladies and Gentlemen of the Jury...

Thank you for your service. Many of you called, e-mailed and responded to the article on Violet the BSN, RN, who began working for a group of dermatologists and plastic surgeons. The office website promoted her as the “sclerotherapy nurse” and dubbed her practice of spider vein treatments as “shrinkning” Violet’s “You’re So Vein” clinic. As part of her contract, Violet negotiated a fee splitting arrangement with the physicians.

Violet treated Walter Scott, a 40 year old single guy, with a significant family history of vein problems. Walt is also an avid runner, climber, skydiver, bungee jumper and white water rafter. She examined Walt’s legs and told him he had telangectiasis spider veins.

No physician was involved in the assessment of Walt. He saw only Violet during both visits. Other than noting that he had no known allergies, Violet did not take a nursing or other history or consult a physician. Violet made the determination that he had spider veins, as opposed to some other pathology. Violet decided to perform sclerotherapy. Violet selected the agent, strength, dilution and dose to be used and determined the number and site of the injections. Violet explained the risks and benefits of the procedure and Violet witnessed the “Operative” permit. Violet determined the charges for the procedure based on her fee splitting arrangement with her employers and recorded them in the chart. After the procedure, Violet gave Walt follow-up instructions and a recommendation for compression stockings.

Within a week, Walt was back at the office complaining of ankle edema and pain and blistering at one of the injection sites. Walt was then referred to one of the physicians. Ultimately, Walt suffered from moderate to severe ulceration at one of the sites. He required several months of treatment and two surgeries. He now has permanent scarring at the site and sustained mild, but permanent, decreased range of motion in the ankle. His ability to run and climb and participate in many of his athletic activities has been adversely affected.

The Jury

The jury was not unanimous. A few nurses were prepared to let Violet off “with a stern warning.”

Was Violet negligent? Did she have a duty of care to Walt? Did she breach that duty by violating one or more standards of care? Were the resulting injuries to him caused by her failure? Was he damaged as a result?

YES

Was Violet negligent per se? Did she violate state statutes? Was Walt harmed as a result of such violations?

YES

Was Violet practicing medicine without a license?

YES

Or, can a nurse diagnose a medical condition, such as spider veins, select a treatment modality, provide informed consent, prescribe and use a drug for an intravenous injection and recommend post-operative treatment and care, ... within the scope of nursing, all without any consultation or input by a physician?

NO

Was Violet practicing beyond the scope of her RN license?

YES

Was Violet liable for the use of a misbranded drug in violation of federal law? Should she be liable for using a drug that is not FDA approved outside of a bona fide research protocol?

Some nurses commented that Violet was wholly ignorant of anything about research protocols, which is also apparent. Interestingly, some nurses did not agree, stating that since Violet was not intentionally or knowingly using the drug in violation of the statute, she should not be held liable. In other words, they did not believe that she had any responsibility to know about the drug that she was using and whether or not it was approved for that use!

So, with that in mind, it is not surprising that the Jury was significantly more divided on the issues of intentional and constructive fraud.

Was Violet liable for intentional and constructive fraud? Did she intentionally fail to tell Walt that the drug was not approved by the FDA for any use? Did Violet fail to tell him that she was not licensed to diagnose and treat medical conditions? Did her failures cause Walt to agree to undergo the procedures and was his consent detrimental to him?

YES and NO

My sense from reading the comments was that the nurses responding genuinely believed that Violet did not intend to deceive Walt. But, they did not seem to take into account any responsibility on Violet’s part to find out whether the drug was approved for the procedure she was doing, The nurses seemed to overlook the individual responsibility on Violet’s part to know the limits of her practice or to make a diligent effort to find out whether what she was doing was within the scope of nursing practice. In other words, she could not intentionally violate the Nurse Practice Act if she did not know what it said!

One comment that was frequently seen was the vagueness of the Virginia Law. Nurses want to know what constitutes the practice of nursing. But the law is unclear and imprecise. Virginia provides few, if any, advisory opinions, unlike some other states. Sadly, nurses often wait until they are before the Board in an investigation to learn the Board's position on their practice.

Damages?

If any of the above answers are yes, how much would you award Walt in damages? Assume that he had $25,000 in medical expenses, plus pain, suffering, emotional distress, permanent disfigurement and permanent loss of range of motion and loss of the enjoyment of recreational activities.

For the most part, the Jury was not very sympathetic to Walt. Compensatory damages are

(continued on page 14)
those damages which compensate or pay back the injured party for losses including medical bills and pain and suffering. Compensatory damages are usually related to the injured party proving some losses and are related to the injured party proving some intentional and wrongful conduct on the part of the defendant.

One juror awarded $4 million in compensatory damages and $1 million in punitive damages. Most awards were much smaller, with about half the respondents not awarding any punitive damages whatsoever. The awards overall failed to take into account the legal expenses accrued by Walt in filing his suit, such as attorneys’ fees and expert witness fees. Consistent with the verdict, few jurors awarded any damages under the Virginia Consumer Protection Act.

Other Remedies

A number of jurors mentioned that the physicians should also be held accountable for allowing her to practice in this manner. This nurse was employed by the physicians group, even though she was compensated based on a percentage of fees generated. The legal concept of “respondeat superior” or “let the master answer” means that the employer is legally responsible for the acts of the employee done within the course and scope of employment.

In this case, all the physicians were aware of Violet’s actions and should have been aware of the fact that she was in violation of the Nurse Practice Act. Recalling the days when nurses were “protected” by a practice agreement with a physician for prescriptive authority.

Would you believe that the doctors did not support Violet? Their attorneys argued that Violet should have known her actions were in violation of the Nurse Practice Act and that they, as physicians, were not responsible for any of her actions which violated the law.

Curiously, no juror suggested that the doctors be held responsible for allowing the nurse to practice outside the law. Some of the jurors did hold them accountable for some of the damages awarded.

Board of Nursing Action?

A number of jurors did suggest that the nurse’s license be revoked by the Court. This suggestion is troubling in that it indicates a lack of understanding about the role of the Courts and the Board of Nursing.

The case at hand is about the role of the Courts and the Board of Nursing. The court has jurisdiction or authority over civil and criminal matters. In this case, the complaints of negligence and negligence per se were civil complaints. The allegations of fraud and violations of the Virginia Consumer Protection Act are also civil matters. The Court, through the jury, can only decide on those matters over which it has authority or jurisdiction.

The lawsuit brought by Walt dealt only with the civil matters. The plaintiff, Walt, has the burden of proving his case by a preponderance of the evidence.

If the Commonwealth’s attorney or a Federal attorney, a United States Attorney, determined that Violet had violated any criminal statutes, the attorney, on behalf of the Commonwealth or the United States would bring a criminal action against Violet in the appropriate court, which did not occur in this case.

The Commonwealth or United States has the burden of proving, usually beyond a reasonable doubt, that Violet acted in violation of a specific criminal statute (law). The penalties are set out in the statute, itself, and can include fines or imprisonment. Certain statutes dealing with Medicaid/Medicare billing (not applicable here) also include a provision for excluding a healthcare provider from participating or even from working for an employer who receives state or federal Medicaid/Medicare funding as a penalty.

Some jurors suggested that Violet should lose her license, although one suggested “a stern warning.” Jurors cannot make decisions about the license of a professional. The Board of Nursing (BON) [or, for the physicians, the Board of Medicine] has the exclusive authority to grant licenses to professionals. Likewise, the Boards have the exclusive authority to take all and any actions against practitioners’ licenses.

But, is this action automatic? The answer is NO. First the Board has to find out about the juror’s verdict or the criminal conviction. The National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB), are alert or flagging systems intended to facilitate a comprehensive review of the professional credentials of healthcare practitioners, providers, and suppliers. The NPDB contains information on the following actions against physicians and dentists: (1) adverse license, registration, or certification actions; (2) unfavorable peer review, quality review, and quality control actions and; (3) professional society membership actions. In addition, the NPDB contains the following actions against physicians, dentists and other healthcare practitioners: (4) paid medical malpractice judgments and settlements; (5) Exclusions from participation in Medicare/Medicaid programs, and; (6) registration actions taken by the U.S. Drug Enforcement Administration (DEA). State licensing authorities, healthcare practitioners (self-query), researchers (statistics only), and, in limited circumstances, plaintiffs attorneys.

The intent of the HIPDB is to combat fraud and abuse in the health insurance and healthcare delivery. The HIPDB contains the following types of information: (1) civil judgments against healthcare providers, suppliers, or practitioners related to the delivery of a healthcare item or service, (2) Federal or State criminal convictions against healthcare providers, suppliers, or practitioners related to the delivery of a healthcare item or service, (3) actions by Federal or State agencies responsible for the licensing and certification of healthcare providers, suppliers, or practitioners, (4) exclusions of healthcare providers, suppliers, or practitioners from participation in Federal or State healthcare programs, and (5) any other adjudicated actions against healthcare providers, suppliers, or practitioners. HIPDB information is available to Federal and State Government agencies, health plans, healthcare practitioners/suppliers (self-query), and researchers (statistics only). Similar to the NPDB, the HIPDB is prohibited from disclosing specific information on a practitioner, provider, or supplier to the general public.

So, if criminal actions were taken and Violet was convicted, then the BON would be notified via HIPDB query. Likewise, if a juror found Violet liable and there was a PAID malpractice action, judgment or settlement, a report would be made to HIPDB and the BON would learn of the action.

But, BON action on a license is not “automatic.” Based on any report in the HIPDB or NPDB, the BON would initiate its own investigation and the nurse would receive her due process rights under the Virginia Administrative Proceedings Act.

As you may have surmised, this series of events can be very time consuming. The lawsuit itself may likely take years. If Violet appeals a negative verdict, additional years pass before any payment may occur. If Violet were found liable only under the Virginia Consumer Protection Act, would HIPDB even apply? Perhaps not. Then, the BON investigation may take additional time. Meanwhile, Violet has had an unrestricted license to practice.

Note that any of the parties could notify the BON at any time, even before the filing of the lawsuit. Under Virginia Code §54.1-2408.1, any health regulatory board may suspend the license, certificate, registration or multistate license privilege of any person holding a license, certificate, registration, or licensure privilege issued by it with a hearing simultaneously with the institution of proceedings for a hearing, if the relevant board finds that there is a substantial danger to the public health or safety which warrants this action. Institution of proceedings for a hearing shall be provided simultaneously with the summary suspension. The hearing shall be scheduled within a reasonable time of the date of the summary suspension.

Several jurors stated that if Violet had been “certified” to do sclerosing therapy, she would not have had any of these problems. Certified by whom? What is the relationship between certification and the Nurse Practice Act? To be continued... ♦

Andrea J. Sloan is a nurse and an attorney whose practice includes healthcare law, employment law (including representation of professionals in disciplinary proceedings) and bioethics. Comments and questions are invited. 1350 Beverly Road, #115-123, McLean, VA 22101-3961 or e-mail at asloan@lswlaw.com 703.438.9201, 703.438.9201 fax.

1 Informed Consent? By a nurse?
The LEAD Summit 2008 proudly presents: Dr. Audrey Nelson and Cracking the Code of Patient Falls

by Diane E. Scott, RN, MSN

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The Center for American Nurses is exceptionally proud to have Dr. Audrey Nelson, a nationally known expert and researcher in the field of patient and caregiver safety, as part of the LEAD Summit 2008. Dr. Nelson has multiple awards, including the first Magnet Prize Award for Innovation in Patient Safety and the John Eisenberg Award for Individual Lifetime Achievement in Quality and Patient Safety. The Eisenberg Award, established by the National Quality Forum (NQF) and The Joint Commission, recognized Dr. Nelson for her tireless efforts in magnifying the scope of practice for patient safety and advocacy for those with disabilities.

With over 30 years of nursing experience, including the roles of staff nurse, nurse administrator, and nurse researcher, Dr. Nelson is currently the Director of the Department of Veterans Affairs (VA) Patient Safety Center of Inquiry, supervising over 63 research staff and a total budget exceeding $15 million. To find out more about what attendees will learn from her presentation at the LEAD Summit, 2008, we talked with Dr. Nelson about her work.

Center: You have been nationally recognized as a pioneer in patient safety, how did you initially become involved in patient safety research and the patient safety movement?

Beginning in 1980, I started my work focusing on the functional outcomes in persons with a spinal cord injury. During this time, I focused primarily on rehabilitation outcomes and research within this specialty population. In 1998, Dr. Robert H. Roswell, who then was the Director of VISN 8 (Veterans Integrated Services Network), approached me about research opportunities in patient safety. He convinced me my work in functional outcomes was closely matched to preventing adverse events, and so my research area was realigned to include patient safety. In 1999, when the Institute of Medicine released its report, To Err Is Human: Building a Safer Health System, patient safety and the reduction of errors made front-line news. Fortunately, I already had a patient safety center and had a head start in developing research to focus on this now very-public issue.

Center: Could you provide an overview of your research related to the patient safety movement and patient falls?

Patient safety is a very broad subject and with many different loci. Part of our success was to drill down deep in one area—preventing adverse events associated with mobility/immobility. These are high cost, high volume problems in nursing. One of the adverse events we have focused on is patient falls. Other areas include wandering, pressure ulcers, and safe patient handling.

Center: How will attending this conference help nurses acquire strategies to reduce the risk of falls among patients?

One of my favorite things to do is take a complex nursing practice problem with thousands of journal articles written about it and to help develop solutions with research based practice. Attendees at this conference will examine past paradigms of looking at patient falls. I hope to change their perspectives of this issue and strategically consider different interventions designed to increase patient safety.

With patient falls, we have over three decades of research, yet we have never ‘cracked the code’ to prevent patient falls. During the conference we will strategically examine whether our focus on preventing falls has actually jeopardized patient safety, by encouraging nurses to chemically or mechanically restrain patients so they would be safe. We inadvertently prevented our patients from being active and mobile, and interfered with quality of life.

Now, in retrospect, I firmly believe that good quality of care means something needs to happen to make our patients who are at risk more active. If we start to look at how we should get our patients more active and mobile, while providing environments that prevent fall-related injuries rather than preventing falls, I think we can finally make significant progress in this area.

For example, imagine a nursing home or a rehab center that looks at the environment, and floor surfaces, which will prevent injuries when a person is becoming more active. If we change our paradigms and increase mobility with the at-risk populations, we may see an increased fall rate, but falls with less significant injuries. This is because of a focus on fall protection and being proactive with increasing the mobility of the patients, which promotes health and quality of life.

Center: During LEAD Summit 2008, you are going to speak to the needs of safe patient handling and the bariatric patient. What do you see as the greatest challenge in the implementation of safe patient movement techniques and strategies in today’s healthcare settings for the unique needs of the bariatric patient?

Obesity is an incredible rising problem within the United States and is becoming a crisis for healthcare organizations and the nurses who care for these patients. The Center for Disease Control’s website shows, state by state, the rate of obesity among the United States populations throughout the past years, and how it demonstrates an epidemic. Nurses have not been equipped to deal with this population in a dignified way. Obese patients are very vulnerable as a result, both emotionally and physically. Even normal nursing practices place nurses and patients at risk because simple nursing interventions are physically challenging.

My talk at LEAD Summit 2008 is going to focus on standardizing nursing practices for the bariatric patient and describing technological innovations. I am thrilled to present at this conference and hope that attendees will gain a greater appreciation of their roles as nurses and leaders in safe patient handling.

Attendees at LEAD Summit 2008 will have the opportunity to hear more about Dr. Audrey Nelson’s groundbreaking work on patient falls and safe patient handling. For more information about LEAD Summit, please visit www.leadsummit2008.org.
Outstanding Member Award Guidelines/Application

1. The award is presented on an alternating schedule with other VNA awards. Solicitation deadlines will be posted to invite nominations. The award will be presented at the October 25, 2008 meeting of the Delegate Assembly.

2. Nominations must be submitted to the Chairman of the Council of District Presidents no later than August 31, 2008. Mail or send by email to the VNA office at kmahone@virginianurses.com

3. The award may be given to a member only once.

4. Nomination process:
   • Complete the appropriate Nomination form accompanied by a current vitae or resume of the individual being nominated.
   • Submit either a letter or other documentation (e.g., a newspaper article; relevant letter from a third party), which supports at least 6 of these criteria:
     a. positive interpersonal relationships with peers and VNA
     b. enthusiasm and role modeling
     c. leadership abilities
     d. integrity
     e. dedication to profession
     f. upholds Code of Ethics
     g. community activities
     h. professional activities
     i. willingness to take a stand on professional issues
     j. mentoring activities
     k. innovative ideas
     l. special

Name: _____________________________________________
Address: ___________________________________________
VNA District: ______________________________________
E-Mail Address: _____________________________________
Place of Employment: ______________________________
Work Address: _____________________________________
RN License #: ______________________________________
Individual Submitting Nomination: ____________________

VNA District: ______________________________________
Day Phone: ________________________________________
E-Mail Address: ___________________________________
In Lynchburg, Virginia, a community collaboration between our nurses, Alumnae Associations, and our local Legacy Museum of African American History of Lynchburg and Central Virginia has resulted in a new and exciting exhibit in the “The Healthcare Career Center.”

Centralia’s nursing staff helped raise over $75,000 to support the establishment of this unique Center. It was constructed as an innovative space within the hospital that provides school groups and others the opportunity to learn about the history of nursing in our community and options for nursing education and careers. This center showcases available healthcare careers as interactive computers and videos show the many faces of nursing.

The newest exhibit in the Center highlights the African American healthcare professional. This exhibit describes the diverse careers of African Americans who provided healthcare in Lynchburg and the difficulties they faced in achieving their goals. It was produced by the Legacy Museum of African American History in June 2000 as their inaugural exhibition with support from the Central Health Foundations.

For two centuries African Americans in Virginia have relied on remedies made from plants and used charms and medicines passed down from African traditions to care for themselves and their loved ones. Formal medical training for African Americans as doctors, nurse pharmacists and dentists were restricted by segregation laws to institutions like Howard University and Meharry School of Medicine that were established after the Civil War.

During this time in Lynchburg, African American doctors were excluded from practicing in hospitals and were confined to general office practice in black neighborhoods, while public health nurses faithfully cared for school children and African American citizens who were unable to afford private doctors. Healthcare and health educations remained segregated until the 1964 Civil Rights Act and the establishment of Medicare and Medicaid in 1965 finally brought the divided health system together.

Today, disease and mortality rates for African Americans are still notably high, but the presence of black health professionals in medical facilities encourages more African Americans to seek professional healthcare. Getting African Americans to enter the health professions remains a crucial step to improving healthcare for all.

In addition, exhibits allow children to experience the breadth and depth of nursing from the neonatal unit to hospice care. The interactive exhibits help children learn about body systems, ways to prevent infections, CPR, and give students a “look” into an operating room.

Centralia also showcases the history of nursing in the area and feature the various schools of nursing and how nursing education has changed over the years. The exhibits demonstrate how some aspects of nursing education have not changed since the hospital opened in 1924. The healing touch, caring for our patients, “always putting the patient first” are themes they want to instill in future generations of nurses.

There is also a “grab and go” exhibit for a speakers bureau of nurses to use when we are asked to present at school career days. The Center is open to the public daily and special tours are available by appointment for local school groups.

This space will serve to educate young people about the rewards of healthcare careers. A virtual tour of the Healthcare Career Center is available at www.centralhealth.com.

**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 approves 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 June 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 $200.00 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:

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<tr>
<th>Time</th>
<th>Activity</th>
<th>Contact Hours</th>
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<tr>
<td>8:30-9:30 am</td>
<td>General Session (1 contact hour)</td>
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<td>9:30-10:30 am</td>
<td>General Session (1 contact hour)</td>
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<td>10:30-10:45 am</td>
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<td>General Session (1 contact hour)</td>
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<td>12:45-1:45 pm</td>
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<td>1:45-2:45 pm</td>
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<td>2:45-3:00 pm</td>
<td>Break</td>
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<td>3:00-4:00 pm</td>
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<tr>
<td>4:00-5:00 pm</td>
<td>General Session (1 contact hour)</td>
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Individual educational program approval:

- 1-4.99 Contact Hours reviewed: $75.00
- 5-9.99 Contact Hours reviewed: $150.00
- 10-17.99 Contact Hours reviewed: $200.00
- 18+ Contact Hours & over reviewed: $225.00 plus $5.00 per additional C.H.

If you have further questions about fees charged for CE approval, please email us at vncaea@virginianurses.com.

**District 2 News**

Phyllis Brown Whitehead, RN, MSN, CNS, CHPM and Dianna Boyd, RN, MSNc, CNS, AE-C will speak at Advanced Practice Nursing Conference: Care Through the Ages at the Mayo Clinic, Rochester Minnesota on July 24-25, 2008.

They are discussing the Clinical Nurse Specialist role in Instrument Development and validation. Their tool: The Comfort Scale for Mechanically Ventilated Patients (MVES) was developed and piloted among three critical care units. The tool contains five dimensions rated on a three point likert scale.

Ms. Whitehead, the legislative chair for district 2 received both her BSN and MSN from Radford University. She is certified in Pain Management and Hospice and Palliative Care, having had ELNEC training in 2003. She is currently employed at Carrollton Roanoke Memorial Hospital as a CNS in Pain Management and Palliative Care and is studying for her PhD in Health Promotions at Virginia Tech.

**TNCC Receives Grant from Williamsburg Community Health Foundation to Strengthen Health Care Workforce Initiatives**

The Williamsburg Community Health Foundation has awarded $985,000 in grants to the Thomas Nelson Community College Educational Foundation, Inc. to strengthen healthcare workforce initiatives at the College. One grant of $60,000 will provide scholarships for TNCC nursing and other allied health students while another totaling $25,000 will support a Health and Medical Services Pathway project that targets Historic Triangle area high school students.

A three-year grant, the nursing and allied health scholarship funds will be provided to the College at $20,000 each year to help current students offset the costs of their education. To be eligible for a scholarship, students must be either employed by Eastern State Hospital or a local healthcare facility or be a resident of the greater Williamsburg community. The grant will also assist graduate TNCC nursing students who will enroll in Bachelor of Science in Nursing Programs at four-year colleges and universities in Virginia.

The second grant will enable TNCC to partner with Williamsburg/James City County high schools to strengthen the career path in health sciences for young students; thus, the College can meet the region’s need for trained healthcare professionals as the Health and Medical Services Pathway project can lead to a two-year degree or industry certification for students. Funds provided by the grant will purchase instructional materials, supplies, and equipment such as manuals and anatomical models. The grant will also cover some of the project’s marketing and promotional costs.

Thomas Nelson’s Educational Foundation, a private, nonprofit, tax-exempt organization, enhances access to higher education opportunities at the College by reducing financial barriers for students. Also a non-profit, private organization, the Williamsburg Community Health Foundation strives “to improve the health of the people living in Williamsburg and surrounding counties in collaboration with community partners” through its grant making.

For more information about the scholarships, please call the College’s Scholarship Office at (757) 825-2684 or contact the Educational Foundation at 825-2719 for other details about the grants.

**The College’s Scholarship Office at (757) 825-2684 or contact the Educational Foundation at 825-2719 for other details about the grants.**
2008 Open Offices for the Virginia Nurses Association

- Secretary
- Commissioner on Nursing Education
- Commissioner on Work Force Issues
- Commissioner on Nursing Practice
- One Director at Large
- Three (3) members of the Committee on Nominations

Qualifications:
To be eligible to serve as an officer, a member shall hold current membership in a District and not concurrently serve as an officer or director of another organization if such participation might result in a conflict of interest with VNA. The terms are for two years.

The Secretary shall be responsible for ensuring that records are maintained of all meetings of the Delegate Assembly, Board of Directors, and Executive Committee.

Each Commissioner shall coordinate the activities of the commission and serve as ex-officio a member of all committees that are the sub-structural units of that commission.

The Director at Large shall be a staff nurse who represents that constituency in all Board of Directors business and transactions.

Details on Commission Positions:

The responsibilities of the Work Force Issues Commission are to:
- provide a forum for the discussion of work force issues, including human rights of nurses, issues related to diversity, and the work environment
- assist nurses in developing skills to respond to current and emerging healthcare environments
- assist nurses in increasing their awareness and understanding of the dimensions of diversity, including ethnicity/culture, age, gender, physical abilities, religion, race and sexual/affectional orientation and their effect on client care and the workplace
- advocate and support the systematic study of work force and diversity issues within nursing and healthcare and their subsequent application to nursing practice.

Nursing Education Commission:
- identify priorities and issues for education in Virginia that are within the scope of the VNA
- promote collaboration among educational groups within Virginia
- promote collaboration between education and practice
- implement activities to maintain accreditation of VNAs Continuing Education Approval and Provider status

The sub-structural units are:

1. Continuing Education Provider Committee, which shall:
   a. consist of at least six (6) members;
   b. act as consultants for the provider unit on continuing education programs; and
   c. adhere to American Nurses Credentialing Center (ANCC) criteria and meet all requirements to maintain accreditation.

2. Continuing Education Approval Committee which shall:
   a. consist of at least nine (9) members from the various geographic areas of the state to include members representing a cross section of nursing practice if possible;
   b. assume the leadership role in promotion and implementation of the ANA standards of continuing education for nurses;
   c. review and approve continuing education activities and providers in adherence with ANCC criteria; and
   d. adhere to all ANCC criteria and meet all requirements to maintain ANCC accreditation.

The responsibilities of the Nursing Practice Commission are to:
- provide a forum for discussion of current healthcare practice/trends and their impact on nursing care of individuals, groups, and communities
- promote standards, positions, and policies for nursing care of individuals, groups, and communities
- advocate for optimal healthcare of vulnerable populations
- promote ethical decision-making among nurses
- advocate and support the systematic study and dissemination of research in nursing and its subsequent application to practice
Biography & Consent to Serve Form for VNA Elected Officials
(Offices elected in even numbered years shown in shading)

Please Type or Print:

Name: _____________________________________________________________________________________________________

Address: ___________________________________________________________________________________________________

Telephone (Home): _____________________________________ (Work): _____________________________________________

Employer: _____________________________________ VNA Member? ____Yes ____ No

Title/Position _______________________________ E-mail Address: _____________________________________________

VNA District: _______ Membership Exp. Date: __________________

Education:

School/College _______________________________________________ Degree/Diploma ___________ Date ___________

Relevant Experience:

Professional: ____________________________________________________________________________________________

Civic: ___________________________________________________________________________________________________

Organizational: ___________________________________________________________________________________________

VNA District & State Levels: _______________________________________________________________________________

Other or additional experience can be put on the back of this page.

I wish to run for the following office of the Virginia Nurses Association. I understand the duties and
responsibilities involved in this office and, if elected, I agree to serve, abiding by the VNA Bylaws, the VNA
House of Delegates and Board policies and actions, and the ANA Code for Nurses.

______ Secretary  ______  Commissioner on Work Force Issues

______ Commissioner on Nursing Education

______ Director At Large  ______  VNA Committee on Nominations (3)

______ Commissioner on Nursing Practice

Here is my statement (on reverse side or separate sheet of paper) on what I think the duties and priorities
for this office are and relevant experience I have had:

____________________________________________________________________________________________________________

Signature of Candidate Date  Signature of District President/Officer Date
Welcome New & Returning Members

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<th>District 1—Far SouthWest</th>
<th>Nancy New</th>
<th>Mary Melody Agbuya</th>
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<td>Janet Mosley</td>
<td>Christine Narad</td>
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<td>District 2—New River/Roanoke</td>
<td>Teanessa Atkins</td>
<td>Amanda Nickerson</td>
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<td>District 4—Southside/Hampton Roads</td>
<td>Claudia Fontenot</td>
<td>Lori Todd</td>
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<td>Janice Ganderson</td>
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<td>Caroline Goler</td>
<td>Jackie Wavelet</td>
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<td>District 5—Richmond Area</td>
<td>Andrea Kline</td>
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<td>Diana Yanero-Albert</td>
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<td>District 6—Mid-Southern Area</td>
<td>Brittany Collins</td>
<td>Nancy New</td>
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<td>Glenda Ireland</td>
<td>Mary Melody Agbuya</td>
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<td>Laura Knight</td>
<td>Judith Rogers</td>
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<td>District 8—Northern Virginia</td>
<td>Evita Abeleda</td>
<td>Tracy Thuigpen</td>
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<td>District 9—Mid-Western Area</td>
<td>Elisabeth Caison</td>
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<td>District 10—Peninsula Area</td>
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<td>District 11—Eastern Shore</td>
<td>Elisabeth Caison</td>
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<td>District 12—Northern Shenandoah Valley</td>
<td>Sarah Bunting</td>
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<td>Reann Cummings</td>
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<td>Kathryn Zirkle</td>
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</table>
**MEMBERSHIP NEWS**

**State Nurses Association Membership Application**

8515 Georgia Avenue • Silver Spring, MD 20910 • (301) 628-5000

**DATE _________________**

**Last Name/First Name/Middle Initial**

Home Phone Number

**Credentials**

Work Phone Number

Basic School of Nursing

**Home Address**

Fax Number

Graduation (Month/Year)

Date of Birth

**Home Address**

E-mail

**City/State/Zip**

UAN Member? Not a Member of Collective Bargaining Unit

Member of Collective Bargaining Unit other than UAN? (Specify)

**Employer Name**

Employer Address

**Employer City/State/Zip 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

**Choice of Payment (please check)**

- E-Pay (Monthly Electronic Payment)
  This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize my Constituent Member Association (CMA/ANA) to withdraw 1/12 of my annual dues and any additional service fees from my account.
  - Checking: Please enclose a check for the first month’s payment ($20.83); the account designated by the enclosed check will be drafted on or after the 15th of each month.
  - Credit Card: Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

**Monthly Electronic Deduction Authorization Signature * SEE BELOW**

**Full Annual Payment Authorization Signature * SEE BELOW**

Please Note: $5.42 of the CMA member dues is for subscription to The American Nurse. $16 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.

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by the CMA is not deductible as a business expense. Please check with your CMA for the correct amount.

**Amount Enclosed**

**CHECK #**

**Bank Card Number and Expiration Date**

**Authorization Signature**

**Automated Annual Credit Card Payment**

**Printed Name**

**Amount: $**

**Employer Code**

Approved By _________________ Date _________________

**Expiration Date ________ / ________**

**AMOUNT ENCLOSED**

**MEMBERSHIP APPLICATION**

**Sponsor, if applicable __________________**

**SNA membership # __________________**