The role of nurses is paramount in the shift of focus to prevention through their leadership of interdisciplinary teams, which must include consumers. Nurses play a primary role as care coordinators and are educated and capable to lead the needed shift of focus to prevention and wellness. The IOM Report, *The Future of Nursing – Leading Change, Advancing Health*, recommends that opportunities should be expanded for nurses to lead and manage collaborative efforts alongside physicians and other members of the healthcare team to improve health outcomes and reduce costs. As healthcare in this country continues to be reshaped, nurses have a significant opportunity to be involved in a number of different ways. This could be through the healthcare organization/system where the nurse practices, participation in professional organizations such as ONA and ANA as well as specialty organizations, or within governmental and private agencies, the key is involvement and collaboration.

As a nurse in Oklahoma, how can you be involved? One way is to get involved with ONA and ANA. Another is to serve on a workgroup for the Oklahoma Network, a state action coalition of the *Future of Nursing: Campaign for Action*. To find out more about these opportunities go to the ONA website.

With nurses’ focus on person-centered care of the “whole” person, I believe we are the pivotal link for the changes that must occur in the U.S. healthcare system. I look forward to working with you!

Kindest regards,
Cindy

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**Executive Director’s Report continued on page 3**
Thanks for making Nursing Positively Possible!
Dickey Recognized at Oklahoma Mentor Day

Longtime ONA member, Claudine Dickey was one of 35 Mentors of the Year who were recognized at the first Oklahoma Mentor Day at the State Capitol, Jan. 16. She was named Mentor of the Year by Oklahoma City, First’s Kids Hope USA program.

“The goal of our first Oklahoma Mentor Day was to recognize outstanding mentors from all types of youth mentoring organizations around the state and to provide fun, educational activities for the honorees and their mentees to share,” said Beverly Woodrome, director of the Boren Mentoring Initiative.

Since 2006, Dickey has been mentoring a young boy, raised by his grandparents, who experienced a major crisis. Dickey supported this family throughout the situation and helped him successfully reenter school.

★

Marie Davis, Kids Hope USA coordinator; Claudine Dickey, Ph.D., Kids Hope Mentor of the Year; and Cathy Manuel, minister for the community, First Baptist Church of Oklahoma City

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Executive Director’s Report continued from page 1

Again this year cutting the state income tax, reducing waste and downsizing government have been on top of the list. This doesn’t mean that our issues will be lost or forgotten; in fact, we see these issues as integral to our work. Cuts to the state income tax translate into less money for health care, education – PK-12 and Higher Ed as well as roads and bridges. By the time you read this, the Legislature may have adjourned. Hopefully you will have responded to our Legislative Alerts and our state agencies, schools and hospitals won’t be having to think about more cuts that will affect their ability to deliver the services they are authorized to provide.

I hope that you had a great Nurses Week and that this provides you with insight of how the Oklahoma Nurses Association works to celebrate the great and important work you do year round. ★
Introduction to the CTN

The increasing number of clinical trials being conducted in Oklahoma is stimulating the demand for qualified experienced clinical trial nurses (CTN). Registered nurses have an opportunity to play a fundamental role in the research process by serving as a CTN conducting clinical research trials. Clinical Trial Nurses may have oversight for the safety effectiveness concerning the study design and conduct while monitoring human research subject protection (FDA, 2010). The American Nurses Association’s (2001) Code of Ethics for Nurses with Intepretive Statements states that “the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient” (ANA, 2001, p. 23). The American Association of Colleges of Nursing (2006) identifies the role of the CTN as an advanced practice nurse includes formal training in evidence based practice guidelines, leadership skills, and problem identification within the practice setting of the health care system (AACN, 2006). A graduate level educational background further prepares the CTN to interact at an intellectual and professional level with research scientists as well as initiate research studies (AACN, 2006).

The CTN Scope of Practice and Titles

The role of the CTN emphasizes collaboration, evaluation of outcomes, evidence based practice research, according to the Code of Ethics for Nurses (ANA, 2010b). Rickard et al. (2006) identified the work domains of a CTN as a researcher, manager, clinician and clinical educator. A description of administrative and clinical roles is seen in Table 1. According to Sheilds & LaRue (2010), there are multiple “titles” for the research nurse: research coordinator, research nurse, study coordinator. It is noted in the literature that the education and training for each “title” vary widely and there are currently no set regulatory guidelines to define the various patient advocacy is an essential component of the CTN role. The CTN oversees study subjects’ safety and rights while patients are enrolled in clinical trials. Clinical trials enroll patients to provide information about the effects, safety and influence of a particular intervention or intervention on health and illness (Fowler & Stack, 2007). Clinical trials may involve determining the safety of an investigational products or device as well as the incidence of adverse effects (Catania; 2012, Poston & Buescher, 2010).

Clinical trials

Clinical trials are an important step in the research process and represent the transition of laboratory study to patient applications. The length of time between treatment development and use in the healthcare setting requires a considerable amount of time and financial support. The National Institute of Health (NIH) Road Map Initiative identified that the nursing profession is currently underrepresented within the research community (NIH, 2009). CTN’s actively interact with research subjects and investigators, facilitating protocol methods that impact practice outcomes within the health care setting (Grady & Edgerly, 2009). Interacting with other multidisciplinary team members, CTN’s provide quality data oversight and they are the driving force behind clinical research trials (Poston & Buescher, 2010). Formal use of the CTN in clinical trials varies widely across the United States. Nursing professionals may be involved in the research process at different levels: from basic data collection to formalized roles of the CTN. As the role of the CTN evolves, it is important for nurses to acquire the training and education consistent with the importance of the position. Clinical research trials are considered the “gold standard” of clinical research propelling the CTN into a high demand and rewarding career (Pelke & Edgerly, 1997). Of note, the intense and rigorous studies in Oklahoma, 755 are actively seeking study subject recruitment and enrollment according to ClinicalTrials.gov. The CTN promotes and advocates for human subject protection, safety and rights. It is pivotal time for nurses to become front line members of the research team in Oklahoma.

Challenge to the Readers

We recommend that you determine who the individuals are within your institution that are conducting clinical research trials and ask if they “adequately trained and qualified personnel” according to the federal regulations. It is our hope that by raising attention regarding the significant roles, responsibilities and, yes, the opportunities for the CTN that this will stimulate nursing interest in this role. We hope that interest will be both for using this information to ask informed questions about the nurses working with clinical trials in your agency and for promoting more nurses to consider being a CTN.

Helpful Web Links:

(look up clinical trials) http://clinicaltrials.gov/ct2/results/term=oklahoma
(FDA Running clinical trials) http://www.fda.gov/Drugs/AboutDrugs/CenterForDrugEvaluationAndResearch/ucm291413.htm

References

The Obesity Epidemic in Oklahoma: What Can You Do?

Amy Hutchens
The University of Oklahoma, Faculty, Clinical Instructor

The Problem

Trust among America’s Health and the Robert Wood Johnson Foundation recently predicted that by 2030 half of Americans will be obese (Levi, Segal, St.Laurent, Lang, & Rayburn, 2012). Currently, it is estimated that 65% of Oklahomans adults are overweight or obese (OSDH, 2011). Oklahoma received an F on the state health report card for both food and vegetable consumption physical activity rankings (OKSDH, 2011). This is not only an American problem, the World Health Organization (2013) has estimated that 1.4 billion adults worldwide over age 20 are overweight. The WHO has estimated that 40 million children worldwide under age 5 are overweight. Research has indicated that overweight children are highly likely to become overweight adults (National Institute for Health Care Management Foundation, 2003). The issue of obesity and overweight is a complex yet preventable issue. Nurses across all specialty areas encounter this issue frequently, and are in a key position to develop and implement interventions to treat this complex and growing problem.

Obesity is defined as “an abnormal increase in the proportion of fat cells” (Daniels, 2011, p. 944). BMI is widely accepted as a measurement tool for overweight and obesity. Measurement cut off criteria for overweight and obesity may vary, but clients with a BMI of 25-29.9 kg/m2 are generally considered overweight (Daniels). A BMI value greater than or equal to 30 are considered obese, and a BMI greater than 40 kg/m2 are considered morbidly obese (Daniels). In children percentile rank is used as an indicator for overweight with a percentile rank of greater than or equal to 85 being at risk for overweight and greater than or equal to 95th percentile being overweight (Barlow, 2007). Obesity and overweight is a major risk factor for cardiovascular disease, diabetes, osteoarthritis and some cancers (WHO, 2013). It is a major cause of morbidity and mortality. It is estimated that obesity costs Oklahomans 1.2 billion dollars in health care costs each year (OKSDH, 2013). Overweight and obesity is a complex yet preventable issue, and nurses are in a key position to intervene.

Get Involved

The Nurses Role

Recent research has indicated that if parents lose weight, their children will lose weight (Boutell, Cafri, & Crow, 2012). This means that adult health acute care and community nurses can impact not only the clients under their care, but also the client’s children, their own offspring, and future generations. Nurses can help to combat the problem of overweight and obesity by leading by example. A recent study conducted found as much as 55% of nurses are obese (University of Maryland Baltimore, 2012). The ANA currently has a program in place to help nurses maintain a healthy lifestyle. The program is called Healthy Nurse. Nurses can sign up to receive e-mails from the Health Nurse at the ANA website.

Nurses can get involved in the prevention and treatment of obesity in their daily practice routines. Nurses across all specialty areas and levels of expertise encounter the issue of overweight and obesity in their physical assessments. Assess what the client is currently doing to address the issue, and examine if they are aware of the issue. Nurses can collaborate and consult with physicians, mid-level practitioners, and dieticians on what nutritional and exercise regimens would be appropriate for their clients.

Get Involved in Local Initiatives

Nurses can assist in the implementation of Oklahoma’s current plans in the prevention and treatment of overweight and obesity. The Oklahoma Physical Activity and Nutrition Program (OKPAN) and Oklahoma Fit Kids Coalition collaborated in the development of the Oklahoma Physical Activity and Nutrition State Plan titled “Get Fit, Eat Smart.” This model was developed as a guide for use by advocates to implement change in Oklahoma (OKSDH, 2008). The nursing profession is in a key position to function as an advocate for change by assisting with the implementation of this model. The model focuses on 5 different areas for interventions including Physical Activity, Breastfeeding, Screen-Time, Healthy Eating, and Surveillance and Evaluation (OKSDH, 2008). “Get Fit, Eat Smart” outlines evidenced based interventions that can be implemented in many settings including the healthcare setting. These interventions include health care provider’s incorporation of assessment of diet and exercise regimens of clients, implementation of training programs for healthcare providers in areas nutrition and physical activity, and counseling of patients to reduce non educational screen time (OSDH, 2008). “Get Fit, Eat Smart” can be accessed at http://www.ok.gov/health/index.html

Oklahoma Turning Point Initiative is an organization developed to enhance the health status of Oklahomans. Turning Point seeks input from communities as to what the specific needs are, and plans interventions based on that data (Oklahoma Turning Point Council, 2013). Interventions have ranged from development of walking trails for communities to implementation of initiatives to improve nutrition in schools (OK Turning Point Council). The Oklahoma Turning Point Council also offers applications for the implementation of “Certified Health Programs” at your business, campus, community, restaurant, or school. Nurses can get involved in their own communities by contacting their local Turning Point representative. Find more information at http://www.okturningpoint.org/index.html

These are just a few of the ways that nurses can get involved in the prevention and treatment of obesity and overweight. It is and will continue to be an issue that nurses need to address this epidemic. Nurses are in a key position, with continual exposure to this issue, frequently, and are in a key position to make necessary changes in practice and advance effective prevention and treatment: An overview for health professionals. Retrieved March 26, 2013 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3123702


References


Over the last 43 years of my academic career, the evaluation process for nursing program accreditation has influenced and guided my growth as a faculty and administrator of nursing programs. The intent of this paper is to share my experiences of the program evaluation process, as outlined by the National League for Nursing Accrediting Commission (NLNAC). I have participated in this process since 1970.

I have been on the “receiving” side of this process 12 times and the “giving” side more than 50 times. From these experiences, to me, there is less stress in being an evaluator than being evaluated.

Being an evaluator is an honor and privilege that should be taken seriously. It does come with a commitment for hard work, spending several hours preparing and writing the report during and after the visit.

To be an evaluator, one must be employed by a school of nursing that has successfully achieved NLNAC accreditation. NLNAC is the only nursing organization that has been granted authority by the US Department of Education to accredit all levels of nursing programs. Upon completion of a workshop, one becomes a member of the “pool” of evaluators.

There are two evaluation cycles each year: fall and spring. The NLNAC staff will request, via electronic format, the dates of your availability. Assignments are sent and you agree to the visit.

Visit our website for more information on job openings and benefits.

I email the chair and introduce myself. I stress that this is a PEER REVIEW process: the team are colleagues. I acknowledge that this is stressful, but the intent is not to add to that stress.

My motto in this program evaluation process is to treat the faculty as I would want to be treated. Hopefully, this will set the stage for a quality evaluation and a trusting relationship that will benefit all: students and faculty.

The most significant thing that needs to be done prior to the visit is to thoroughly review the SSR and support materials sent. During the first reading, I make notations of questions: these usually refer to unclear or missing information. During the second reading, I am entering data into the body of the report using the SSR template. A third reading is on the plane.

It is critical that program evaluators attain temporary permission to access password-protected information. Review of online and web site materials are part of the preparation process. Arrival at the site early on the day prior to the visit is critical so as to have time to review supporting documents. These materials can be moved to the hotel room for review. The days of the visit are long, filled with lots of meetings, and information gathering. Evenings are filled with quick dinners and lots of writing. The program chair should participate in all meetings except faculty and students. It is essential to keep the chair informed of how the visit is going. The 45-minute exit interview with the chair provides detailed information. The proposed accreditation recommendation is shared first followed by details. In this way, the chair is able to hear the details provided. The chair has the right to select the audience for the public meeting. This may be a few administrators and faculty or the entire university community.

The team finalizes the report which is sent electronically to NLNAC within a week of the visit. Courtesy dictates sending thank-you notes for all of the attentions provided. I do this via email within a week.

To summarize, serving as a program evaluator for NLNAC is voluntary; one gives time and expertise as a contribution to the profession. It has been my experience that I have gained more from the experience than I have given. It does take four days out of the work week plus significant time preparing. I challenge and encourage my colleagues to join the team of program evaluators.

References
By 2020, the annual cost of injuries from falls occurring in hospitals is expected to exceed $40 billion. Up to 12% of hospitalized patients fall at least once during their hospital stay. Falls are one of the top five sentinel events in hospitals (Johnson, et al., 2011). Patient falls account for 40% of adverse events. (Ireland, et al. 2010). Falls lead to increased length of stay and poorer outcomes, including death. As nurses, it is our desire to provide the safest environment of care for all. Fall risk assessments are performed on every patient admitted to the hospital. However, research reveals that a fall risk assessment tool alone does not prevent falls, but rather predicts those who are at greater risk for falls. No fall risk assessment, including the Morse, John Hopkins, STRAFIFY, of care.

Studies do reveal, however, that education does reduce the amount of falls. Education, combined with follow up, reduced falls by 5% (Haines, et al., 2011). A study by Johnson et al, 2011, was conducted over a 3 year period, using a sample of 11,378 patients. The study included a multi-interventional approach using the John Hopkins fall risk assessment, physical interventions, patient and family education, and a hospital wide culture of safety. Results from this study showed that falls decreased by 16.6% and the number of injuries from falls decreased by 9.4%. This translates to a savings of $6.4 billion in healthcare dollars annually. We propose the following protocols be implemented in hospitals to decrease falls. With these interventions:

- Use of an accepted fall risk assessment tool. Questions specifically should address circumstances pertinent to previous falls: new medication, slippery surface, environmental hazard, etc.
- Physical interventions which would include:
  - Universal color system for arm bands, non-skid footwear, and alert signs on the patient doors and beds. For our project, we chose the color yellow, which indicates caution.
  - Bed alarms, bed in low position, and call lights within reach.
  - Regular toileting, asking specific questions of patients, and conducting frequent patient rounds.
  - Move high fall risk patients closer to the nursing station.
  - Elimination of environmental hazards.
  - Patient and family education.
- Involve the patient and family in their plan of care.
- Individualize room posters. These posters be mass ordered and laminated, with fill in the blank areas to indicate risks.

- Individualized handouts about fall risk and prevention.
- Patient teach back of education received.

- Hospital wide culture of safety.

- Training for all hospital staff about understanding the risk of falls, patient outcomes and cost to hospital. The training would be provided to all who work in the hospital, including the outsourced personnel.

- Universal color system of the hospital's culture of safety surrounding falls will be positively impacted. Successful implantation of a multi-interventional program of education has proven to decrease the number of falls. Healthcare dollars saved from the decrease of falls will be freed to use in appropriate means as each hospital sees fit.

References:


The Executive Leader Doctor of Nursing Practice (EL DNP): The rest of the story

Dr. Betty Kupperschmidt, RN, NEA-BC, Director, Nursing Administration, OUHSC College of Nursing

In a recent issue of JON, an author painted a picture of the Doctor of Nursing Practice (DNP) with a focus on the clinical doctorate developed to prepare Advanced Practice Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP). In the words of the late Paul Harvey, this article tells the rest of the story: There are no clinical advanced practice DNP for those nurse leaders interested in nursing administration/executive practice. These programs are variously termed Nursing Administration, Executive Systems Leadership, and Executive Leader.

For the purposes of this article, Executive Leader Doctor of Nursing Practice (EL DNP)* is used. The two types of programs are similar in many ways. Students complete many of the same courses together, such as translational research, evidence-based practice, quality focused courses, knowledge management, informatics, and practice inquiry, the series of courses in which students fully develop and implement their scholarly projects. Major differences are that the EL DNP comprises courses focused on organization and systems theories and advanced executive leadership competencies (See Exhibit) whereas the clinical DNP focuses more on individual or aggregate patients.

Many EL DNP programs note that these programs are designed for current nurse executives at the divisional or above level with supervisory oversight of essential services or functions. Curricula prepare students to enact multiple dimensions of administrative responsibilities within varied healthcare environments with a focus on innovative strategies critical for success in complex organizations and systems. Critical content comprises healthcare policy and ethics, quality and safety, and of course strategic best practice leadership competencies. Program lengths vary widely among universities, ranging from 39 to 48 semester hours. Students prepare major papers in the format of manuscripts suitable for submission for potential publication.

Most of the universities offering the EL DNP require intensives. Intensives are times when students are required to come to campus, usually offered at the beginning of the Spring and Fall semesters with some intensives offered during the summer. Again, the requirements vary widely among universities. During these Intensives, students may discuss and apply content derived from course completion and learn from national professional leaders. They also may discuss the proposed focus of their scholarly projects.

Across the nation, many incumbent Nurse Executives have grown up within varied healthcare environments with a focus on innovative strategies critical for success in complex organizations and systems. Critical content comprises healthcare policy and ethics, quality and safety, and of course strategic best practice leadership competencies. Program lengths vary widely among universities, ranging from 39 to 48 semester hours. Students prepare major papers in the format of manuscripts suitable for submission for potential publication.

Over the years, as organizations morphed into more and more complex systems, these nurses ‘grew’ into their positions. Many are currently facing retirement within the next 3 to 5 years. The compelling question must be asked: How can healthcare replace the wisdom these highly effective administrators take with them when they leave their complex systems? One answer seems to be preparing the Nurse Executive or Chief Nursing Officer, whatever their title, at the Executive Leader, Doctor of Nursing Practice level.

For those readers desiring additional information, the author advises that you access the American Association of Colleges of Nursing’s web site (aacn.org) and query DNP programs. No organization to date maintains a listing of Executive Leader Doctor of Nursing Programs; thus some search time is required. Readers may also contact the author. The Exhibit contains fictitious course to give readers a sense of the courses they might find in the EL DNP programs.*

Exhibit: Leadership Core courses for the Executive Leader Doctor of Nursing Practice

Current and Evolving Roles, Challenges & Opportunities
Organizational Foundations for Change
Management of Program, Project, and Innovation
Leadership of Program, Project, and Innovation
Organizational and Systems Leadership
Global Perspective of Healthcare
Healthcare Informatics / Knowledge Management
Advanced Executive Leadership
Finances and Economics of Leadership of Healthcare Administration
Scholarly EL DNP Projects / Directed Scholarship: 6 semester hours

* fictitious courses developed for the purposes of this article.
When most of us started our nursing careers, we became nurses to help and serve others. We never thought we would have to be concerned about the cost of care for our patients or cost of care for health care facilities not to mention the nation. Times have changed, as we all know. Health care in the United States for 2011 was 17.9% of the gross domestic product, one of the highest cost percentages for health care in the world. Hospital care and physician/clinical care accounted for 51% of the costs. ** The majority of the costs in health care services consume much of our monetary resources from our personal and economic budgets. Thus, in today’s world, it is of paramount importance that from staff nurses to the Chief Nursing Officer, nurses must understand their personal home finances, their workplace finances, as well as the healthcare industry as a whole.

Business Plans: A Basic Skill

One of the basic skills all nurses should have is developing business plans. I teach finance in the graduate program, and I’m always a little surprised how many nurses really do not have a basic understanding of health care finances. They do not know the cost of the supplies they use in providing patient care much less manpower costs of their own time. But many of them find health care finance very interesting when they are enrolled in a basic financial management course. The final project in the course I teach is how to write a basic business plan.

You may be asking, “Why ask nurses to learn how to write a basic business plan?” Some people will tell you that it is not important. Nurses only need to take care of patients. But nurses need to know what it costs to take care of their patients. The more efficient we are in delivering health care, the more the patient, the organization, and society as a whole benefit from less economic strain. We need to understand what supplies and resources provide the best quality at the least costs. The only way we can do that is to actually identify and understand the costs (both indirect and direct) of supplies and resources and the cost associated with specific procedures/processes.

Purpose Served by Business Plans

What purpose does business plans serve? Business plans provide an organized method to analyze the costs of care. They provide the nurse with a template to figure out the current cost of care delivered, or they can help develop proposals for new techniques and processes to improve patient care quality. With basic business planning skills, nurses are better equipped to speak the financial language with the administrative level so the administrators understand how their decisions impact patient care. Without this ability, nurses are hampered in expressing themselves regarding cost of care issues as well as innovative ideas to improve patient care.

Strategies the nurse leader can use to assist novice nurse leaders and staffs to understand the finances of their care delivery in their areas of responsibility are:

- Assist staff nurses to determine the cost and charges of the supplies used most frequently in their areas.
- Ask the nurses to determine what their patients would find most helpful regarding their care
- Assist nurses to evaluate which of their actions create costs for the patient and the organization
- Explain how changes in patient acuity and patient volume affect staffing and the budget
- Explain how charges are generated and how documentation relates to billing
- Share the monthly budget results with the staff and have them assist in solving budget variances.
- Coach nurse managers and staff to consistently ask:
  - Are we doing the right things?
  - Are we being effective in our care and as cost efficient as possible?
  - To what extent are my attitudes towards assuring quality and efficient care affecting the success of my care delivery?

Summary

In conclusion, no nurse should shy away from understanding the finances of the health care world. We must all embrace the need to understand the costs of care. As we gain this basic understanding, we can excel in demonstrating ideas to improve health care in the most efficient manner, a winning combination in today’s financially focused world!

** References available from the author

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Business Plan Basics for the Nurse

Pam Crawford, MS, MBA, RN, NEA-BC

The Oklahoma Nurse • Page 9
Evidence-Based Nursing Practice: An Exemplar of Collaboration

Cindy M. Lyons, MS, RN, CNE and Diana Mashburn, PhD, RN-BC, CNE

April 25, 2013, the University of Oklahoma College of Nursing and the Northeastern State University Nursing Program hosted the 10th annual Evidenced-Based Practice (EBP) Nursing Symposium.

The intent is that students engage in addressing current practice issues with an assignment requiring application to the real world of nursing while synthesizing content from their entire BSN experience. Students from OU attend class in a blended format while NSU’s program includes students from out of state who complete their projects online. Delivering podium and poster presentations in a public forum is a tremendous learning opportunity for students from both programs, more formal than the classroom setting, while continuing to remain student friendly.

Further dissemination of the findings occurs after the Symposium through a traveling “road show” of the posters to hospitals, in the region, during the year. This occurs in both metropolitan and rural hospitals. Additionally, slides from the podium presentations, as well as the Symposium Proceedings Manual are posted to the OU College of Nursing website, which can be accessed worldwide (http://nursing.ouhsc.edu/Research/ebp.cfm).

In 2011, the annual EBP Nursing Symposium was held in conjunction with the biennial State-Wide Nursing Research Day. The combined event was extremely successful, as it brought nurses from across the state together for a day focused on current EBP and research. Additional partnerships were forged with professional nursing organizations such as the Oklahoma League for Nursing and Institute for Oklahoma Nursing Education and Sigma Theta Tau. The networking and energy was exciting! ★

A special “thank you” is extended to Dr. Evelyn Acheson for having the vision and leading the creation of the first EBP Symposium in 2004.

References

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CLASSSES ENROLLING NOW!
“Travel Giggles”

Diane Sears, RN, MS, ONC

It’s summer time. Have you scheduled your vacation yet? If not, don’t let the following become your stress reality. Get thyself out of town, even if you can only afford to trade houses with a friend or family member. “I am amazed when I look back on my day and realize all the faraway places my mind has traveled. Afghanistan, the polar ice caps, the Bay of Bengal, the terraces of Machu Picchu… the halls of Kilimanjaro, the deep sea depths of the Mariana Trench, Boise, Idaho…” Wife: “Would you mind going to the store for me? We’re out of milk.” Husband: “Okay, but only in my mind.” (“Pickles,” cartoon, 06/06/12)

My sister went alone to Hawaii, driving itinerary in tow. Upon arrival, she went to the car rental counter only to discover that her driver’s license was expired.

“I know you believe you understand what you think I meant by what I said…but what you don’t realize is that what you think you heard me say is not what I meant to mean! Wife: I want to divorce him, but first, I want to ring his neck!” (“The Born Loser,” cartoon, 02/10/13)

“Caution…when someone tells you to get a grip…apparently around their neck is not what they meant…Who knew?” (email 04/13)

“Health tip: If you can’t afford a doctor, go to the airport. You’ll get a free x-ray and breast exam and if you mention Al Qaeda, a free colonoscopy.” (email 01/13)

“Returning home from dinner out one night, I started feeling sick. Suspecting food poisoning, I called the restaurant’s manager. “I cannot believe that happened,” the woman said. She sounded genuine. Did you sound genuinely shocked. “What did you order?” “I had the stuffing.” “That’s weird,” she observed. “Usually it’s the meat loaf.” (Reader’s Digest)

Diane Sears, RN, MS, ONC

The ice in my wife’s veins has melted! Thanks, global warming.” (“Bizarro,” cartoon, 01/23/13)

Checkups before leaving
MD: I understand you had a problem with how my nurse weighed you in. Patient: She only let me step on the scale once! On my home scale, the numbers often vary a little each time I step on it… so I always weigh myself at least a dozen times, then go with the lowest reading!” (“The Born Loser,” cartoon, 09/29/10)

“You’re still piling on the pounds, Cosmo. Nurse, let’s get a reading for him on the scale.” Nurse: “weight or richter?” (“Shoe,” cartoon, 02/05/03)

Nurse getting ready to perform venipuncture: “Hold still—you’re going to feel a small pinch in your budget.” (“Speedbump,” cartoon, 10/16/09)

Pharmacist: “This anti-depressant works best if you take it with water lapping near your hammock on a Caribbean beach.” (“Speedbump” cartoon, 12/05/09)

Traveling with the elderly
Printed on back of t-shirt of man in line, “If lost, return to Rita.” Further up in line was a woman with a t-shirt on whose back read, “Rita.” (“Bizarro,” email 04/13)

“I’m confused is today Thursday? Hmmm, I can’t remember either. Hold on, my pill box says it’s Friday.” (“Beetle Bailey,” cartoon, 08/10/12)

“I’m not old, I woke up, I lifted my arms, I bent my knees, I turned my neck, everything made the same noise” “crrrraaaaaaacccckkkK!” …I came to a conclusion: I am not old, I amcrispy.” (“Bizarro” cartoon, 03/18/13)

“I have finally discovered what is wrong with my brain. On the left side, there is nothing right and on the right side, there is nothing left.” (“Bizarro” cartoon, 03/22/10)

“We kids in the hotel bathroom: “Which is the shallow end? This water isn’t hot or cold—it’s just luke. PJ is drinkin’ all our bathwater and we’re not finished with it yet. A towel fell in the water and it’s too heavy to lift out. How many laps do I hafta swim to make a mile? Jeffy didn’t take off his shoes and socks! How ‘bout turnin’ on the shower so we can pretend its rainin’?” (“Family Circus,” cartoon, 08/12/12)


“Zzz, Zzz, Beep, Beep, Beep! Oh, no!! Sob!! There’s nothing worse than accidentally setting your alarm for the one morning you get to sleep in.” (“The Born Loser,” cartoon, 02/10/13)

Returning home from dinner out one night, I wonder where I put my keys, I wonder how I put my weight on, I often wonder why I wonder…” (email 2013)

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The number of individuals using social networking sites such as Facebook, Twitter, LinkedIn, and YouTube is growing at an astounding rate. Facebook reports that over 10% of the world’s population has a Facebook presence while Twitter manages more than 140 million Tweets daily. Nurses are making connections using social media. Recently, the College of Nurses of Ontario reported that 60% of Ontario’s nurses engage in social networking (2010).

Social networks are defined as “web-based services that allow individuals to 1) construct a public or semi-public profile within a bounded system, 2) articulate a list of other users with whom they share a connection, and 3) view and traverse their lists of connections and those made by others within the system (Boyd and Ellison, 2007).

These online networks offer opportunities for rapid knowledge exchange and dissemination among many people, although this exchange does not come without risk. Nurses and nursing students have an obligation to understand the nature, benefits, and consequences of participating in social networking of all types. Online content and behavior has the potential to either enhance or undermine not only the individual nurse’s career, but also the nursing profession.

Benefits
• Networking and nurturing relationships
• Exchange of knowledge and forum for collegial interchange
• Dissemination and discussion of nursing and health related education, research, best practices
• Educating the public on nursing and health related matters

Risks
• Information can take on a life of its own where inaccuracies become “fact”
• Patient privacy can be breached
• The public’s trust of nurses can be compromised
• Individual nursing careers can be undermined

ANA’s Principles for Social Networking
1. Nurses must not transmit or place online individually identifiable patient information.
2. Nurses must observe ethically prescribed professional patient – nurse boundaries.
3. Nurses should understand that patients, colleagues, institutions and employers may view postings.
4. Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
5. Nurses should bring content that could harm a patient’s privacy, rights, or welfare to the attention of appropriate authorities.
6. Nurses should participate in developing institutional policies governing online conduct.

References
President Obama’s 2014 Budget Proposal Supports Stronger Health Care System

SILVER SPRING, MD – The American Nurses Association (ANA) advances the nursing profession by fostering high standards in professional practice, advancing the educational preparation of nurses and promoting the health of the nation. The Obama administration’s budget proposal reflects a commitment to expanding services and care delivery to millions of Americans receive high quality health care.

The president’s budget proposal recommends $25.1 billion for Title VIII Nursing Workforce Development Programs, an approximately $20 million increase over the president’s previous budget proposals. These vital programs serve to recruit new nurses into the profession, promote career advancement within nursing, and allocate nurses to critical shortage areas.

“With the proposed increase to Title VIII funding, the Obama administration continues to recognize the invaluable contribution that nurses make in the delivery of care and the need to strengthen our primary care system,” said ANA President Karen A. Daley, PhD, RN, FAAN. “This proposed budget takes the long view and reflects tough choices by the Obama administration, while still supporting programs that are needed to transform the health care system and improve health for all.”

ANA also applauds the Obama administration for additional critical health care investments, including:

• $80.1 billion in discretionary funding for the Department of Health and Human Services, a $3.9 billion increase over FY 2012 funding levels, for investments in Affordable Care Act (ACA) implementation, medical research, and other priorities.

• $803.5 million for the Centers for Medicare and Medicaid Services’ insurance exchange operations.

• $235 million in funding for new mental health programs, including $50 million to train master’s-level mental health specialists as master’s-level nurse practitioners, counselors, and social workers.

• $1.8 billion for community health centers that will provide key primary care services for underserved communities.

ANA recognizes the difficult task lawmakers face in these economic times, especially during this time of sequestration and the need for significant deficit reduction. However, ANA has consistently asserted that nurses should never be a political or partisan issue. That is why ANA will continue to advocate for programs that address the health care demands of our nation. Learn more about ANA’s advocacy efforts.

National Quality Organization Endorses Performance Measures Used by American Nurses Association to Assess Nursing Care in Hospitals

SILVER SPRING, MD – A leading national organization that recommends health care performance standards has endorsed two quality measures developed by the American Nurses Association’s (ANA) National Database of Nursing Quality Indicators® (NDNQI®) to improve patient safety in hospitals – patient fall rate and patient falls with injury.

Patient falls are among the numerous performance measures reported by NDNQI, the nation’s most comprehensive database of nursing performance indicators. The database is used to evaluate and improve the quality of nursing care and associated patient outcomes in hospitals. The National Quality Forum’s (NQF) endorsement of these measures will help hospitals measure the true impact and intervene at the right time to prevent patient falls and related injuries.

NQF is a nonprofit organization that builds consensus on national priorities and goals for performance improvement and endorses national consensus standards for measuring and publicly reporting on performance. ANA is a member of NQF and participates in various roles in NQF’s evaluation and endorsement process for quality standards.

National Nurses Week.

Reflect on and Celebrate Your Contributions to Quality and Innovation

As nurses, our attitude is naturally to “do whatever it takes” to provide high-quality care for patients. With a laser-like focus on person-centered care, we may not even recognize when we are innovative in solving a problem or improving the quality of care. With demands from all directions to improve quality, increase efficiency, and reduce costs, it’s time to appreciate our strengths as innovators and share our insights and discoveries broadly wherever health care practices and policies are determined and implemented.

This year’s National Nurses Week theme, “Delivering Quality and Innovation in Patient Care,” encourages nurses to think in new ways about making systemic changes that ensure the health care system work better for patients. Think about the many ways you innovate and improve care. Sometimes, it’s a creative solution addressing a problem of patient care; other times, it’s a novel approach to care delivery that could be applied to a whole class of patients with similar conditions.

We’re all concerned about quality improvement, whether we’re researchers, administrators, or clinical nurses. You have ideas to offer, and the nursing profession and our patients need your contributions.

I encourage you to hone your instinct for creativity and persist in your pursuit for answers. Keep asking fundamental questions: How can we improve? Would another way work better? Are we following the best practice, based on evidence? Our dedication to inquiry inevitably will produce innovations and raise quality.

Take a few moments to reflect on and celebrate your contributions to your patients, workplace and community. Let a nursing colleague know how much you appreciate their contributions and how they make a difference for others. We are members of a noble, trusted profession that is indispensable to our country. Take some time to recognize the difference we make.

Thank you for your advocacy, leadership, and commitment to patients, and for supporting your profession and association. It makes me proud of the nursing profession. Together, we can create the environment where our innovative thinking and devotion to quality will flourish.

With sincere appreciation,
Karen A. Daley, PhD, RN, FAAN
President, American Nurses Association

Measuring Quality, Improving Outcomes

One significant way in which nurses are improving care and patient outcomes is through ANA’s quick-improvement tool, the National Database of Nursing Quality Indicators® (NDNQI®), the largest comprehensive database of nursing performance measures with 1,900 participating hospitals.

Using data, nurses identify problems and develop solutions within their unit teams to improve the quality of care and outcomes, such as reducing pressure ulcers, infections, and patient falls. Whether or not you work in an NDNQI hospital, you can lead in the same way.
Choctaw Nation

Rural, tribal, 43 bed, state-of-the-art facility located in scenic southeastern Oklahoma in Talihina is seeking qualified and energetic Nursing candidates. Choctaw Nation prides itself in providing superior Customer Service. Prime candidates must have a strong dedication to provide unparalleled quality service and product, and a real desire to help our Tribal community.

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For more information contact Gary Lawrence DON at (918) 567-7185 or go to www.chseta.com.

The Oklahoma State Department of Health is seeking to fill positions around Oklahoma to conduct inspections in nursing facilities, hospitals, surgery centers, home care agencies, dialysis centers, and other health care settings. Extensive 2-5 day overnight travel required. Extensive training provided.

Preference given to RNs with valid permanent Oklahoma nursing license.

Full job descriptions and qualifications are available at:

http://careers.health.ok.gov/

Mail: Office of Human Resources, Oklahoma State Department of Health
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Fax resume to 866.310.4081

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American Nurses Association/Oklahoma Nurses Association

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Please type or print clearly. Please mail your completed application with payment to ONA.

Last Name: ___________________________ First Name: ___________________________

Middle Initial: _______________________

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City: __________________ State: ______ Zip: ______ County: ______

Last Four Digits of Social Security Number: ________

Home Phone: __________ Work Phone: __________ Cell Phone: ________

Home Fax: __________ Work Fax: __________ Pager: ________

Employed at: _______________________

Employer’s Address: ___________________________

Academic Degree: __________________ Certification: __________

Graduation from basic nursing program (Month/Year): __________ RN License # State: __________ Date of Birth: __________

Membership Categories (please choose one category)

❖ ANA/ONA Full Membership Dues

Employed full or part-time $22.63 per month or $265.50 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❖ ANA/ONA Reduced Membership Dues

Not employed RNs who are full-time students, newly-licensed graduates, or age 62+ and not earning more than Social Security allows $11.56 per month or $132.75 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❖ ANA/ONA Special Membership Dues

62+ and not employed, or totally disabled $6.04 per month or $72.88 annually. Includes membership in and benefits of the American Nurses Association, Oklahoma Nurses Association and the ONA District Association.

❖ ONA Individual Membership Dues

Any licensed registered nurse living and/or working in Oklahoma $11.25 per month or $135.00 annually. Includes membership in and benefits of the Oklahoma Nurses Association and the ONA District Association.

Membership Application Form is also available. For more information, visit www.oknurses.org.

Communications Consent

I understand that by providing my mailing address, email address, telephone number and/or fax numbers, I consent to receive communications sent by or on behalf of the Oklahoma Nurses Association (and its subsidiaries and affiliates, including its Foundation, District and Political Action Committee) via regular mail, email, telephone, and/or fax.

Signature: ______________________________ Date: __________

SIGNATURE REQUIRED BELOW

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I authorize ONA/ANA to charge my credit card listed below for the annual dues on the 1st day of the month when the annual renewal is due. “SEE AT RIGHT”

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Please type or print clearly. Please mail your completed application with payment to ONA.

Last Name: ___________________________ First Name: ___________________________

Middle Initial: _______________________

Street or PO Box Number: ___________________________

City: __________________ State: ______ Zip: ______ County: ______

Last Four Digits of Social Security Number: ________

Home Phone: __________ Work Phone: __________ Cell Phone: ________

Home Fax: __________ Work Fax: __________ Pager: ________

Employed at: _______________________

Employer’s Address: ___________________________

Academic Degree: __________________ Certification: __________

Graduation from basic nursing program (Month/Year): __________ RN License # State: __________ Date of Birth: __________

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Signature: ______________________________ Date: __________

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Please Contact:
Saint Francis Hospital
Nancy Roper, RN — nroper@saintfrancis.com, 918-502-8303
Jackie Perez-Hicks, SPHR — jhicks@saintfrancis.com, 918-502-8311
Toll Free – 800-888-9553

Warren Clinic
Jenna Bledzki — jbledzki@saintfrancis.com, 918-488-6081
Janel Lowe — jlowe@saintfrancis.com, 918-488-6048

Saint Francis Hospital South
Joanna Mahan — jmahans@saintfrancis.com, 918-307-6092

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