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Quarterly circulation approximately 223,000 to all RNs, LPNs, and student nurses in Ohio.

Whose Job Is It, Anyway? The Nurse's Role in Advocacy and Accountability

Developed by Pam S. Dickerson, PhD, RN-BC

This independent study has been developed for nurses who wish to increase their understanding about the nurse's role in advocacy and accountability. **1.1 contact hours** will be awarded for successful completion of this independent study. The author and planning committee members have declared no conflict of interest. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. Identify forces affecting nurses and nursing today.
2. Discuss strategies to strengthen nursing practice in today's healthcare environment.

Today's healthcare environment is complex. Change occurs rapidly, technology is advanced, human resources are often slim, and patients present with multiple challenges. Nurses often feel that they are struggling to keep their heads above water and feel a need to focus on the bare essentials of "necessary" care, rather than encompassing care that is "nice" to provide.

What drivers are influencing the environment in which nurses practice?

Technology is sophisticated and often complex, particularly to the novice user. Nurses are expected to use computers for documentation, computerized systems for retrieval of medications, computerized pumps for delivery of certain medications, and computerized devices for controlling selected bodily functions. Simulation laboratories teach nurses how to care for patients by using manikins that can breathe, bleed, alter blood sugars and blood pressures, and even "die." Genetic and genomic research has taken healthcare to the level of "designer" diagnoses and drug dosing specific to a person's genetic make-up and the genes involved in his/her particular disease condition.

There are many fewer nurses than will be required to provide care for those who need it. There are currently approximately 2.8 million registered nurses in the United States. The expected growth rate for registered nurses between now and 2020 is 26%, while the national average for all employment areas is 14% (US Bureau of Labor Statistics, 2013). However, it is estimated that there is a current need for approximately 3 million nurses. By the year 2020, the expected deficit in the number of nurses will be 29%, or more than one-half million fewer nurses than needed. This is exacerbated by the fact that about 1 million nurses will be considering retirement within the next 10 years (HRSA, 2013).

The *U.S. Nursing Workforce: Trends in Supply and Education* was published in 2013 by the Health Resources and Services Administration (available at http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf). Using data collected from a variety of sources, this study shows that the age distribution of RNs breaks down as follows:

Up to 30	14.8%
31 – 40	23.5%
41 – 50	26.8%
51 – 60	26.4%
60+	8.5%

A significant number of these nurses, many with extensive experience and enviable expertise in providing care, plan to retire within the next five to ten years. Even with new nurses entering the profession, the number of departing nurses, and the collective knowledge they will be taking with them, will leave a significant gap in nursing services for years to come.

At the national level, data show that the number of people entering the profession is growing rapidly, with the number of RNs successfully passing the NCLEX exam increasing by 108% from 2001 to 2011 (HRSA, 2013). The largest growth area is in non-bachelors' prepared nurses. Many nurses are returning to school - the number of RN to BSN graduates is estimated to have increased 86% in the past four years. Likewise, the number of masters' and doctoral graduates increased by 67% from 2007 to 2011 (HRSA, 2013).

There are significantly more, and different, types of nursing opportunities available to nurses now than there were ten to twenty years ago. Although the majority of nurses are still employed in "traditional" nursing employment settings such as hospitals, nursing homes, and clinics, increasing numbers of nurses are serving in community roles, occupational nursing, school nursing, military service, and even supporting space missions.

While there is healthy interest in nursing as a career, and enrollments in nursing education programs are promising, there are many more prospective students who are turned away from nursing education programs due to a shortage of faculty and clinical sites available to support their learning needs. The primary focus of graduate programs in the past two decades has been on preparation of advanced practice nurses, who have chosen to practice primarily in clinical settings.

Compensation for services as a clinician has been much higher than for faculty, which has contributed to the shortage of nursing instructors. Many states are now exploring initiatives to make faculty positions more attractive to qualified prospective educators.

Patients have more complex needs and are managed with more high-technology diagnostic and therapeutic regimens. Nurses need a high level of technological sophistication and comfort with operating machines and equipment that support patient care. Nurses also need a high level of knowledge to deal with an increasingly complex care in complex healthcare environments. Most importantly, nurses need to have skills in critical thinking, clinical judgment, and data analysis in order to provide safe patient care. To be sure that nurses have a safe level of knowledge to practice, the National Council of State Boards of Nursing has raised the pass rates on the NCLEX-RN® examination, effective in spring of 2013 (NCSBN, 2013).

As the population of the United States ages, the needs of patients will increase. However, because people are living longer, and often have active senior lifestyles, the needs of future "senior citizens" will be different than the needs of elderly persons in the past. Nurses will need to be thorough in their assessment and specific in planning and implementing care for this increasingly large population.

Patients are also better informed today than ever before. They come to the health care environment clutching printouts from their computers or with ideas about appropriate medications based on television advertising. Patient teaching and helping patients and families wade through the wide array of information available will be a key role of the nurse of the future. The nurse must stay knowledgeable in order to have correct information to share with patients and families.

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Ohio Nurses Association, 4000 East Main Street, Columbus, OH 43213

References
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Questions
Contact Sandy Swearingen (614-448-1030, sswearingen@ohnurses.org), or Zandra Ohri, MA, MS, RN, Director, Continuing Education (614-448-1027, zohri@ohnurses.org).

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The Ohio Nurses Association does a lot for the nursing profession as a whole, but what does ONA do for its members?

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NURSING PRACTICE ONA staff includes experts in nursing practice and policy that serve our members by interpreting the complexities of the Nurse Practice Act and addressing practice issues with a focus of ethical, legal and professional standards on a case-by-case basis.

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Go to
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Nursing assistants and technicians are being given responsibility for performance of more and more tasks. Some of these are facility driven decisions, while others reflect changes in law. In some facilities, time study engineers have been hired to determine the length of time required performing various nursing tasks, and these time parameters are serving as benchmarks for expected behaviors. When the focus of care becomes the tasks that are performed, there is a risk of losing sight of the primary focus of nursing – caring for the whole patient. Unless nursing is able to articulate its importance and validate the impact of "care" on quality outcomes, the profession runs the risk of being "out-sourced" to task-providers.

The healthcare system itself is changing. There is more focus on accountability of all providers in all phases of the care delivery process, rather than the silo approach where primary care, acute care, rehabilitation, and long-term care occur essentially in isolation. Quality improvement initiatives focus on root cause analysis of problems and limitations in providing quality care, and then develop educational, practice, and other appropriate interventions to ensure that issues are addressed. Payers, providers, and patients are all more focused on *outcomes* – the "so what" aspect of providing care. It's not just about what we do, but why we do it and what results we get.

What concerns do nurses voice about their work environments?

Frequent concerns of nurses in today's practice environment focus on working conditions, time constraints, and "paperwork" (or "computer work") – all of which are identified as potential roadblocks to providing quality care. Working conditions include such diverse factors as lighting in work areas, noise levels, staffing, availability of resources, and adaptations made (or not) to accommodate needs of older nurses who do not have the stamina and flexibility to physically perform tasks that might be required. The frequency of injuries to nurses, particularly back injuries, has been an area of increasing concern. In fact, national emphasis has recently been placed on establishing and maintaining a safer environment for practice that will help to reduce the incidence of injuries. In fact, the American Nurses Association has published standards entitled "Safe Patient Handling and Mobility: Interprofessional National Standards (ANA, 2013) to address issues related to provider safety in moving and handling patients. A number of research studies have validated the relationship between sub-optimal work environments, errors, and negative patient outcomes (Institute of Medicine [IOM], 2004).

Several initiatives have been undertaken to address the issue of a healthy work environment. In 2010, The Online Journal of Issues in Nursing (OJIN) published a series of articles on this topic (Erickson, J. 2010). Articles in this series address such diverse issues as empowering leaders to build and sustain health work environments, strategies for enhancing autonomy and control over practice, combating disruptive behaviors, and establishing a healthy academic work environment. The American Nurses Association (2013) defines a healthy work environment as one that is "safe, empowering, and satisfying" and advocates a culture of safety in all levels of healthcare organizations.

In 2005, the American Association of Critical Care Nurses (AACN) initiated a program entitled "Establishing and Sustaining Healthy Work Environments: A Journey to Excellence." The standards in this program are skilled communication, true collaboration, effective decision making, staffing, meaningful recognition, and authentic leadership. These standards have been used by many organizations and have reached far beyond the critical care areas. Their value is universal.

Increasing documentation requirements from third party payers, employers, credentialing bodies, and others have increased the non-patient care burden associated with nursing practice. Many nurses have come to view documentation as a "necessary evil" that has to be completed before they can go home at the end of a shift. With this type of focus, it is easy to lose sight of the true value of documentation as a tool to help all health care team members provide quality care.

Use of computers has eased the paperwork burden in some cases, but computerized documentation has created its own set of problems. One challenge has been that different software systems are used in different organizations, and often nurses are not involved in the development or selection of these systems. Implementation of a system that isn't conducive to effective use is, in many cases, more problematic than helpful. The other issue here is that older nurses are often not computer savvy and resist having to learn computer skills in order to perform their jobs. One nurse commented to this author that "The reason I went into nursing is that I didn't know how to type!" Today's nurse, however, must be able to use the computer for data management and for documentation. As computerized documentation becomes more the norm in all healthcare facilities, the focus is shifting from teaching the mechanical aspects of electronic medical records to "meaningful use," or the value of electronic tools in collecting and evaluating data, leading to more effective decision making and higher quality care.

What behaviors do nurses exhibit that interfere with the ability to function effectively and provide quality care?

It has been said that "nurses eat their young." We have often not been nice to each other and have been more challenging than helpful to younger colleagues who join our work teams. Recent comments have suggested that nurses are now beginning to "eat their old" – disparaging colleagues who are older and not able to sustain a fast pace, lift heavy loads, or perform functions as quickly as their younger counterparts. There has been a general sense that young nurses must "pay their dues" and validate their worth before being accepted as a member of the staff. Sociologists and others who have studied this behavior use the term horizontal or lateral violence to describe these actions. Not unique to nursing, the concept of horizontal violence relates to how people strike out against each other when they feel powerless to create change in their own situations (Thomas, 2003). Historically, nurses have viewed themselves as "lower" in the hierarchy of the healthcare system than their colleagues in other areas of service. Nurses have not identified issues and spoken with a unified voice to address these issues and advocate for positive change. More time and energy have been spent in complaining and whining about current conditions than in working to change conditions that are seen as counterproductive to providing "good" care.

Nurses generally are not comfortable with conflict and often practice avoidance behavior rather than confronting the problem issue (Conflict and the nursing workforce, 2006). When nurses do not address areas of concern, they compromise their ability to advocate for themselves. Consequently, the risk of patient and/or nurse injury increases.

Over time, when a nurse is not supported in the work setting and feels powerless to influence change, "burnout" occurs and the nurse is likely to leave the practice environment. In fact, studies of healthcare organizations have found that retaining RNs is the most difficult staffing challenge (Retaining RNs, 2006; Lee, Dai, Park, & McCreary, 2013). For some time, the emphasis of Human Resources departments has been on recruitment. Many of these departments are now expanding their focus to promoting retention. Teaching conflict resolution skills, establishing programs to teach leadership skills to front-line managers, and encouraging nurses to become more active in patient advocacy and safety through participation in process improvement initiatives are strategies that many healthcare facilities are now implementing.

There has been a notable disparity between the student learning experience and the "real world" of nursing practice. While academic preparation involves both classroom theory and clinical practice, the focus is on acquiring knowledge and skills to provide safe care. Transition to the practice environment requires substantial adaptation – using acquired knowledge and skills in a fast-paced, intense healthcare setting. There is a realization, too, that learning is not over – that critical thinking and continual updating are essential to maintaining safe care. Many facilities have established preceptor or internship programs with promising retention outcomes.

Nurses have been taught clinical skills but little in the way of leadership and management skills. While some nursing education programs encompass leadership and management opportunities, many more do not. Even if the student learns these skills in an undergraduate program, the new graduate typically does not step immediately into a formal leadership role. The gap between student learning and implementation in practice leaves the opportunity for the nurse to forget what has been learned and to begin to emulate leadership behaviors of others. Often nurses are "promoted" to management positions based on tenure or excellence in clinical practice, not because of demonstration of leadership skills. When nurses are placed in these leadership roles without the support and education necessary to assume their new functions, they often face extreme difficulty in effective functioning. In fact, dissatisfaction with front-line management is a major cause of nurses leaving clinical practice. Efforts in some facilities to implement leadership development programs have shown great promise.

Another important concept is the fact that leadership and management are not synonymous. One can be a leader without being a manager, and many have experienced working with a manager who has very poor leadership skills. As we move toward a focus on integrative care across the health-illness spectrum, and particularly with the emphasis today on Interprofessional collaboration, it is imperative that *all* nurses realize the critical importance of their leadership in advocating for patients, for the work environment, and for the profession. To emphasize that point, Bleich (2011, p. 5) writes that "nurse leaders can be found at all levels, from practitioners who are novice to expert, in all personality types, and without regard to gender, ethnicity, or age."

What data do we have that supports the "value" of nursing?

The IOM (2004) reports that a major role of nurses in the hospital environment is surveillance, which is defined as "assessment, evaluation, or monitoring" – an important factor in detection of errors and prevention of adverse events. Research reported in the IOM study shows that nursing surveillance is consistently related to lower patient mortality and that there is a strong correlation between organizations that support front-line staff and lower rates of safety-related issues. Nurses also play a crucial role in coordination of care and integration of healthcare services. In fact, one physician author states that "My discovery, as a patient…is that the institution is held together, glued together, enabled to function as an organism, by the nurses and nobody else" (Thomas, 1983, pp. 66-67).

The American Nurses Association has spearheaded development of the National Database of Nursing Quality Indicators (NDNQI). This database collects and evaluates nurse sensitive data from United States hospitals which have chosen to be a part of this project. Nurse sensitive indicators are defined as structures, processes, and outcomes that are directly related to the quantity or quality of nursing care provided in the setting. Analysis of this data has led to linkages with the National Quality Forum, The Joint Commission, and other groups striving to promote quality in healthcare.

Many studies have related nurse staffing and nursing care to patient outcomes. There has been a trend to focus on economic indicators for healthcare operations, often leading to downsizing of nursing staff. However, clinical indicators provide a better measure of the value of nursing. It is important that nursing collect, analyze, and widely share data that supports the connections among nursing care and such factors as error reduction, length of stay, frequency of complications, and patient satisfaction. Examination of quality issues has led to the development of evidence-based practice standards, which are now available for many practice areas and through such web sites as the Agency for Healthcare Research and Quality (www.ahrq.gov) and the Institute for Healthcare Improvement (www.ihi.org).

What is the current impetus for driving change in nursing practice in the United States?

In 2011, the Institute of Medicine released the seminal report, *The Future of Nursing: Leading Change, Advancing Health*. This document clearly emphasizes that nursing is crucial to a successful evolution to a more effective and efficient healthcare system in the United States. Based on research and analysis of nationwide data, the report presents four key messages and eight recommendations. These include:

KEY MESSAGES

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health professionals, in redesigning healthcare in the United States.
4. Effective workforce planning and policy making require better data collection and an improved information infrastructure.

Specific recommendations developed from these key points include:

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1. Remove scope of practice barriers.
2. Expand opportunities for nurse to lead and diffuse collaborative improvement efforts.
3. Implement nurse residency programs.
4. Increase the proportion of nurses with a baccalaureate degree to 80% by 2020.
5. Double the number of nurses with a doctorate by 2020.
6. Ensure that nurses engage in lifelong learning.
7. Prepare and enable nurses to lead change to advance health.
8. Build an infrastructure for the collection and analysis of interprofessional healthcare workforce data.

Through a system of action coalitions established across the country, grassroots efforts are now underway to bring these recommendations to fruition.

As noted above, one of the recommendations of this report is that the number of baccalaureate prepared nurses increase to 80% by the year 2020, in order to address many of the complex issues and challenges addressed earlier in this study. National data from HRSA (2013) indicates that only 55% of the RN workforce is educated at the baccalaureate or higher level. This drops to 34% of RNs living in rural areas of the country. Clearly, the need is great; equally clear is the evidence that higher levels of education are critical to enabling nurses to be leaders and change agents – from the bedside of the patient to the boardroom of the hospital to the halls of the US Congress.

What tools, resources, and behaviors can help us advocate for ourselves, our patients, and our profession?

Know and Use the Code of Ethics. The Code of Ethics for Nurses (ANA, 2000) addresses nine major factors that drive professional behaviors of nurses. The first three of these address the individual nurse and the nurse/patient relationship, the second group of three focuses on the nurse within the system of healthcare delivery, and the final three provisions of the Code address the responsibility of the registered nurse in the development and enhancement of the profession of nursing. The primary obligation of the nurse, according to the Code, is to protect the patient. There is also a duty to provide care to self. How can we provide appropriate care to those relying on our expertise if we are tired, underfed, or uneducated? The Code requires that nurses embrace the profession and serve as advocates for nursing within the healthcare environment and in the public eye.

Know and follow the law and rules regulating nursing practice. The rules regulating the practice of nursing in Ohio (4723-1 to 4723-27 of the Ohio Administrative Code) address the responsibility of nurses to advocate for their patients in a variety of ways. Specifically, standards for safe practice in 4723-4 OAC include such expectations as displaying your credentials when providing care; being respectful of patients' rights, dignity, and confidentiality; being honest in documentation; working collaboratively with other care providers; and questioning prescribed medications or treatments that have the potential for causing harm. Implementation of the nursing process requires, according to rule, use of critical thinking and clinical judgment on the part of the nurse.

Be a good communicator. Work to develop communication strategies that are clear and congruent. Be sure your verbal language matches your nonverbal behaviors. Be sincere in your comments to your colleagues. Learn how to communicate effectively when you are stressed or concerned about another nurse's behaviors. Practice assertive communication rather than aggressive or passive behavior. If you are not comfortable dealing with conflict or confronting other people's problem behaviors, take a class in conflict resolution. Approach your nursing education department about offering such a class for your department or your facility.

Be a role model. Break the chain of "eating our young." Establish a supportive environment for your colleagues. Demonstrate respect, trust, and caring. Work to organize your day, deal patiently with unanticipated changes, and be proactive rather than reactive. Volunteer to be "part of the solution" rather than "part of the problem" when change is needed.

Be assertive. Don't hesitate to speak up to advocate for yourself, your colleagues, and your patients. Keep in mind that both the Code of Ethics for Nurses and the Rules for nursing practice in Ohio require that we serve as patient advocates. Recognize that you have a critical role to play in promoting patient safety, preventing errors, and enabling patients and families to receive appropriate care. You also have a critical role to play in making your work environment a pleasant place to be. Not happy? Assess the situation, develop a plan, enlist the support of your colleagues, and make a change! Rather than spending time and energy whining and griping about current conditions, work to make them better! Work through the "chain of command" in your organization to speak up for changes in the work environment that will promote patient safety, patient satisfaction, and nurse satisfaction. Remember that recruitment and retention are based to a large extent on the satisfaction of staff – and you can help to make your workplace a better place to be. Brown (2006) speaks of a "healing environment" as one that promotes caring for yourself and for others. What can you do to promote self-care in *your* workplace?

Be a team player. Respect the value that others bring to the workplace. Unfortunately, there has often been mistrust and lack of understanding between RNs and LPNs and between licensed nurses and unlicensed assistive personnel. Be sure you know your own scope of practice. Both RNs and LPNs have a legally-defined scope of practice and are accountable for their own actions. By Ohio law, LPNs practice under the direction of a registered nurse, a licensed physician, dentist, chiropractor, or optometrist, depending on the practice situation. This does not mean, however, that the LPN is not able to assess a situation, think through a plan, and participate in implementation and evaluation of that plan. If you are the RN, be clear in your communication and provide the necessary direction to give focus to the LPNs' activities.

When the LPN comes to you with a question or suggestion, listen carefully, acknowledge the work the LPN has done, and then work collaboratively to refine the plan and implement any necessary changes. If you are the LPN, approach the RN with your data, your questions or concerns, and some ideas for possible future actions. Listen, collaborate, and participate in the process of furthering safe care for your patient.

Unlicensed assistive personnel (nurse aides, technicians, assistants, etc.) do not have a license and therefore do not have a legally defined scope of practice. These auxiliary personnel perform tasks that are delegated to them by RNs or LPNs. The role of the licensed nurse is to implement the nursing process, which includes assessment, planning, implementation, and evaluation. The unlicensed person has the ability to perform tasks which assist the nurse, but is not able to assume responsibility for implementing the nursing process. Prior to delegation, the nurse is accountable to assess the patient, assess the situation, and assess the provider. Upon determining that conditions are met that would allow the unlicensed person to perform the task safely, the nurse may delegate the task. After delegation, the nurse continues to monitor the situation to be sure the task is being performed safely and should withdraw delegation if patient safety is at risk. Respect for the role of the unlicensed assistant is critical. It would be impossible to provide appropriate care in today's healthcare environment without the use of well-qualified assistive personnel. Be respectful of their knowledge and ability, value their contributions, and follow the delegation process to be sure you are functioning in a legally appropriate way. Share those delegation rules (Chapter 4723-13 OAC) with your unlicensed assistants – talk about the responsibility each of you has to be sure patient safety is maintained.

Work collaboratively with healthcare providers from other disciplines. Adversarial relationships are counterproductive to a healthy work environment. Do not hesitate to participate in dialogue with physicians, dietitians, therapists, and others who are involved in your patients' care. Keep in mind that you have a vital role to play and important knowledge to share in contributing to the total plan of care for the patient. Be assertive but not aggressive in your communication. Think ahead to anticipate what questions other care providers may have, and be sure you have essential information available when initiating dialogue about patient care issues. The SBAR tool (Situation, Background, Assessment, Recommendations – www.ihi.org) is an evidence-based practice standard for effective communication among healthcare providers that you may find helpful.

Build your team. Be a leader – whether you have the "title" of a management position or not. Help to make your practice environment a quality place where people enjoy being with each other, value other's contributions, and work together to reach common goals. Buckingham and Coffman (1999) have identified 12 factors that contribute to people feeling valued and appreciated in the workplace. These are:

- Knowing what is expected
- Having the resources to do the job
- Having the opportunity to do one's best
- Being recognized for doing good work
- Knowing that someone cares
- Having the opportunity to enhance professional development
- Knowing that one's opinions are valued
- Believing that one's job is important
- Having co-workers who are committed to quality
- Having friends at work
- Receiving regular feedback and progress assessments
- Having opportunities to learn and grow

Assess these factors on two levels. First, think about yourself. Would you say that you have a positive sense of each of these areas? Are there areas where you need additional support or assistance? How can you get the help you need to make your work environment and experience

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more positive? Secondly, think about your colleagues. What do you do to recognize the work that others do? How frequently do you provide feedback and growth opportunities for others? How well do those you work with know what you expect of them? Take the initiative to be a leader in each of these areas. You will be happier, and so will your colleagues!

Be a "magnet." The American Nurses Credentialing Center has a Magnet Recognition Program® to acknowledge healthcare facilities that have demonstrated excellence in "quality patient care, nursing excellence, and innovations in professional nursing practice" (ANCC, 2013). The Magnet model includes components of transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovations, and improvements; and empirical outcomes. Is your organization already a magnet facility? If so, how are you contributing to its continued quality of nursing performance? If not, can you individually display some of the forces of magnetism that have been found to be beneficial to patients, nurses, and facilities? Perhaps your individual behaviors will be the beginning of change within your department, then within your organization.

Be a member. Are you a member of a professional organization? In Ohio, the Ohio Nurses Association and the Licensed Practical Nurse Association of Ohio are major advocacy organizations for nurses. Leaders and members in these organizations work in a variety of ways to promote nursing and advocate for nurses. They are visible at places ranging from the statehouse to the state fair. Through membership, you have an opportunity to be a voice for nursing, to participate in legislative initiatives or professional development activities that will enhance not only your own practice but the professional and public images of nursing.

There are also specialty organizations for various areas of nursing practice. Most of these are organized at the national level; many have local or regional chapters or special interest groups. Membership in an organization specific to your practice area gives you a way to do such things as connect with colleagues from around the city, state, or country, learn best practices, keep up with changes in your specialty area, participate in development of practice standards or benchmarks, and advocate for state or federal legislation that enhances your work.

Be a learner. Never be satisfied that you are "done" learning. The "life expectancy" of healthcare knowledge today is very short. New drugs, treatment strategies, equipment, and research are changing the way we practice on a regular and rapid basis. Don't be afraid to learn new things – and don't be afraid to admit that there's something you don't know! None of us can keep up with everything that's new. Surround yourself with knowledgeable colleagues, seek experts when appropriate, and participate in regular learning activities to keep yourself knowledgeable. Enhance your academic education – there are numerous scholarships and other incentives available to help you return to school. As noted in the IOM report on the Future of Nursing (2011), earning an advanced degree is highly recommended as a strategy to improve both quality of patient care and the ability of the nurse to participate fully in the transformation of the healthcare system. Choose continuing education wisely – focus on what you can learn to enhance you knowledge, skills, and abilities – not just collecting certificates to prove that you've earned enough contact hours for relicensure! Consider becoming certified in your practice area – this is another way to continue to learn and grow, as well as provide evidence of your expertise and continue competence.

The time is now – the place is here – the job is yours! Each of us has the responsibility to advocate for ourselves, for our patients, and for nursing. There are tools and resources that can help you. We cannot "assume" that someone else will speak for us or will take care of our needs. The job is yours, mine, and ours – together we can make wonderful things happen for nursing!

Whose Job Is It, Anyway? The Nurse's Role in Advocacy and Accountability

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:_____

Date:_____ **Final Score:** _____

Please circle one answer.

1. Nursing practice today is affected by both internal issues and public concerns.
   a. False
   b. True

2. There are currently approximately _____ million nurses in the United States.
   a. 1.4
   b. 1.8
   c. 2.8
   d. 2.9

3. The projection of nurses needed in 2020 is
   a. Equal to the projected number of new graduates
   b. Greater than the anticipated number available
   c. Less than half of the current demand
   d. Unrelated to current trends and statistics

4. According to the American Association of Critical Care Nurses, a healthy work environment includes
   a. Good pay
   b. Meaningful recognition
   c. Priority of managers to select days off
   d. Responsibility for personal growth

5. The shortage of nurses today is exacerbated by
   a. Inadequate numbers of nursing faculty
   b. Lack of enrollment in nursing schools
   c. Low interest in nursing as a career
   d. Low pay for nurses

6. There is a documented relationship between sub-optimal work environments and errors.
   a. False
   b. True

7. The primary focus of nursing is
   a. Conducting research
   b. Documenting
   c. Performing tasks
   d. Providing care

8. The concept of horizontal violence relates to
   a. Desire for control
   b. Effective leadership
   c. Patient or family outbursts
   d. Perceptions of powerlessness

9. When dealing with conflict, many nurses choose
   a. Acting out
   b. Avoidance
   c. Confrontation
   d. Procrastination

10. The National Database of Nursing Quality Indicators includes
    a. Behaviors of members of the healthcare team
    b. Hospital-wide issues that affect nursing care
    c. Items specific to the quantity or quality of nursing care
    d. Resources compiled from the federal government

11. The Code of Ethics for Nurses includes a statement that nurses need to care for themselves.
    a. False
    b. True

12. Both RNs and LPNs have licenses and legally defined scopes of practice.
    a. False
    b. True

13. Unlicensed assistive personnel perform tasks when they receive
    a. Authorization
    b. Delegation
    c. Direction
    d. Licensure

14. You are the RN on a busy long-term care facility unit. An LPN comes to you with assessment data and a question about the plan of care. Your best response is:
    a. Do what you think is best. I'm busy here.
    b. OK – I'll take over from here. I should have done this myself in the first place.
    c. I appreciate your assessment of this situation. What thoughts do you have about what might work best?
    d. Why are you bothering me with this? You've been assigned to this patient, so figure it out or call the doctor.

15. You are an LPN in an assisted living facility. There is an RN on call but you know she is at her son's soccer game. You have a concern about a new resident based on your assessment. Your best option is to:
    a. Call the RN to share your assessment data and discuss the plan of care
    b. Implement the standing orders for the facility
    c. Take the initiative to develop the care plan and hope it meets with the RN's approval when she comes in tomorrow
    d. Tell the resident's family that they will have to stay with the new resident tonight in case there is an emergency

16. You are a nurse on a hospital medical-surgical unit. You are aware that several of your colleagues are talking about leaving due to their frustration with staffing, leadership, and support from the organization. Much time is spent in grumbling about current issues and concerns. Your best response is:
    a. Avoid the issue
    b. Build a network of colleagues and develop a plan for improvement to present to your nurse manager
    c. Suggest that the colleagues who are unhappy leave for their new positions and let you know if there's space in the other organization for you
    d. Tell your colleagues that grass is not always greener on the other side of the fence

Evaluation

		YES	NO
1.	Were you able to achieve the following objectives?		
	a. Identify forces affecting nurses and nursing today.	___Yes	___ No
	b. Discuss strategies to strengthen nursing practice in today's healthcare environment.	___Yes	___ No
2.	Was this independent study an effective method of learning?	___Yes	___ No

If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____

4. What other topics would you like to see addressed in an independent study?

The ABCs of Effective Advocacy: Attention, Bipartisanship, & Collaboration

Developed by Jan Lanier, JD, RN

This independent study has been designed to enhance nurses' ability to increase their knowledge about why and how to become politically active. 1.4 contact hours will be awarded for successful completion of this independent study. The author and planning committee members have declared no conflict of interest. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. Discuss the Patient Protection and Affordable Care Act (ACA).
2. Describe the legislative process.
3. Describe the policy process and how it relates to the ACA.
4. Identify the various ways in which nurses can be politically involved.

Nurses are often reluctant or even unwilling to act as advocates on behalf of their profession.
However, sitting on the sidelines in the midst of unprecedented changes within the health care industry means nursing's interests may not be adequately reflected in the emerging public policies.

All nurses can be effective advocates if they have the right tools to do so. After completing this study, nurses will be able to describe how they can increase the effectiveness of their advocacy efforts.

STUDY

Every year legislators at both the state and federal levels enact laws that directly affect nurses and nursing practice. One such law, the Patient Protection & Affordable Care Act (ACA) was enacted in March 2010. Known as health care reform or "Obamacare," this law makes significant changes in the way health care is delivered and how it is reimbursed. The law incentivizes community-based care with a focus on care management and prevention rather than on the sheer volume of services rendered. The ACA, although facing ongoing challenges during its implementation stage, promises to change the face of health care, emphasizing activities that are the foundation of nursing practice. Under the evolving new paradigm, experts predict that admission to the hospital will be viewed as a system failure rather than a normal every day expectation.

Although nurses, as the largest segment of the health care workforce, will undoubtedly experience changes in their practice as a result of the ACA, they have been largely silent during the health care reform debates. Many legislators remark, "Nurses do not show up" when asked to describe their influence over health care reform and other initiatives. By not showing up, nurses are on the outside looking in when they should be front and center at the policy-making table.

Advocacy, seeing a need and finding a way to address it, is the cornerstone of nursing. An advocate builds support for a cause or issue and influences others to take action. The American Nurses Association's *Code of Ethics for Nurses, Nursing: Scope & Standards of Practice, and Nursing's Social Policy Statement,* foundational documents of the profession, all recognize that advocacy goes beyond the bedside and must extend to the profession as a whole. "Nurses are educated to practice within a holistic framework that places a major emphasis on advocacy. So nurses not only have the ability to be an incredible force by their sheer numbers, but policy makers also rely upon nurses' expertise." (Haebler, 2013 p 15).

While others recognize the important role nurses can and should play in the policy-making arena, nurses themselves find this aspect of their professional role distasteful, uncomfortable, and non-essential. "I did not become a nurse to engage in these sorts of political activities. I simply want to take care of my patients. I do not have time to take on yet another responsibility."

While this attitude may appear sound to many, in reality nursing is a regulated profession in a regulated industry. Showing up/advocacy, therefore, is not an option. Rather, it is an obligation.

Contrary to what many believe, engaging in professional advocacy need not be time consuming or a mysterious process taken on only by those who are convinced of its essential nature. All nurses, if encouraged, mentored, and coached appropriately, can make a difference for both their profession and for their patients. Effective advocacy starts with attention—attention to process, people, politics, and perceptions. This study will first address the processes that shape law and rule making. The policy process and factors or forces influencing it will be presented, as will the role of politics in determining the "winners and losers" at the table. People and relational factors will be considered along with how perceptions affect the ultimate outcomes. Finally, the importance of bipartisanship and collaboration to nurses' advocacy efforts will be highlighted, particularly with respect to the role these factors play in determining the staying power of the advocacy endeavor.

Attention to Process—How a bill becomes a law

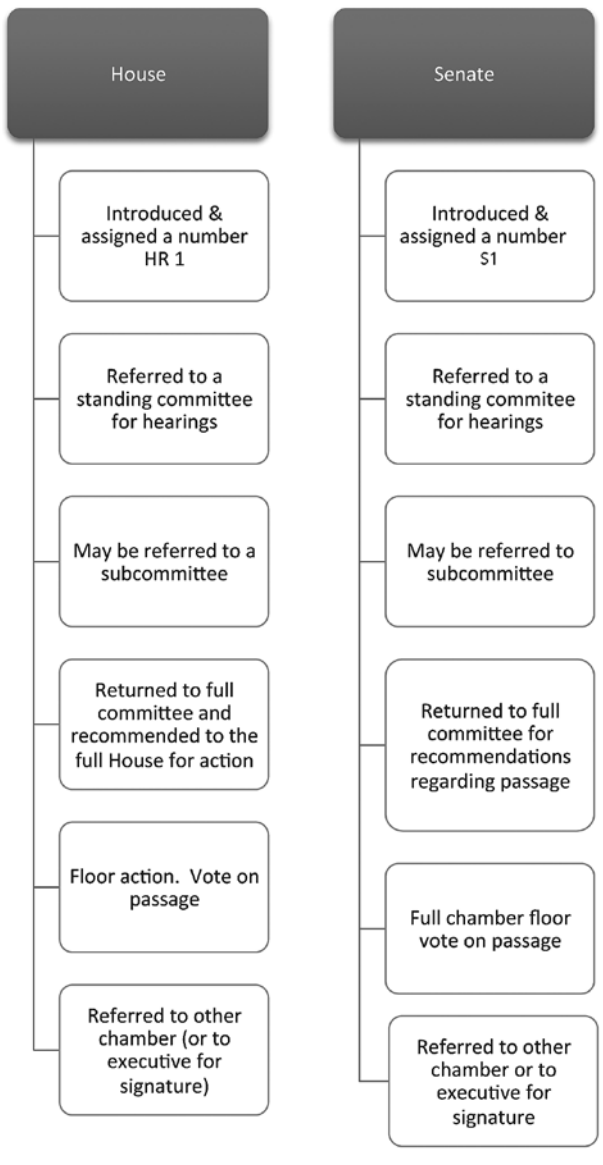
(The information presented here is generalized, recognizing that each state, as well as the federal government, has its own unique nuances that shape the overall process).

Many people study the law making process in junior high and high school government classes thinking that the information is something they will never need to use. They forget the details as soon as the school bell rings. But knowing the rules of lawmaking is important to those who need or want to have an influence over the end results. Like other processes or systems, there are certain norms or rules that govern how the game is played. Just as one cannot play football without knowing what the game is all about, one cannot play in the lawmaking arena without having an idea about the rules of the road.

Legislative Process—

A bill is introduced into the chamber to which the bill's sponsor belongs. Once a bill is introduced, it is assigned a number, sequentially, that it maintains throughout the entire process. That is a House bill would be HR 1 even when it goes to the Senate for action by that body and vice versa.

A proposal must be passed by both the senate and the house within the two-year legislative cycle, (January following a general election where voters select all members of the U.S. House of Representatives and a percentage of U.S. Senate until December after the next legislative general election). Bills can be sidetracked anytime during the process without a formal vote ever being taken.



Introduction

The opportunity for nurses to have input into proposed laws occurs throughout the legislative process, beginning even prior to the bill's introduction. It is not unusual for several versions of a potential bill to be drafted prior to the actual introduction. Nurses can contribute their expertise at this point so that the emerging bill is as accurate as possible.

Determining who will be a bill's sponsor is a very strategic decision. Proponents (nurses) influence the legislator's perceptions about the issue that is being debated and can help bring other legislators on board, perhaps as co-sponsors. Having a sponsor who believes in the issue(s) addressed in the bill helps to ensure that legislative leadership and committee chairmen and others take it seriously. The sponsor must be a watchdog who shepherds and guides the bill through the entire process, which begins with referral to a committee. Referring a bill expeditiously to a standing committee helps get it on the radar screen of committee chairs and other decision-makers. Thousands of bills are introduced during each legislative session. Having someone who believes in the issue that is the subject matter of the bill will help to ensure the proposal gets committee attention in a timely manner. A sponsor should also ideally be a member of the majority party to help guarantee that the bill receives attention, otherwise the bill will likely languish in committee without the legislators having taken any action whatsoever on the proposal.

Committee action

While the committee hearing process may appear spontaneous, in actuality it is well orchestrated. Proponents make sure their positions are represented by witnesses carefully prepared to tell the story that strategists (AKA lobbyists) believe will be the most persuasive. Opponents typically put on the same type of campaign. Nurses are excellent witnesses who have real-life experiences to share that can help lawmakers understand the need for the proposed law. In addition, their technical expertise can be helpful in preparing the bill's sponsor for his/her testimony that kicks-off the committee hearing process. Lawmakers may ask questions of the witnesses and may make recommendations for changes (amendments) to the bill based on the testimony. Again, nurses' expertise can be invaluable as details are worked out.

Committee action may appear to be chaotic to an onlooker with few lawmakers paying attention to what the witnesses are saying. In reality, while the committee process is important, most crucial decisions about contentious issues are made during interested party meetings that occur in legislative offices outside of the public eye. One gets to these key meetings, however, by demonstrating interest during committee meetings.

Bills may also be referred by the full committee to a subcommittee, where more complicated matters can be debated and compromises attempted. Again, while participation in the subcommittee action is critical, nurses must realize that much of the most meaningful work occurs in less formal settings. Once its work is completed, a subcommittee sends the bill back to the full committee for the ultimate decision as to whether the bill will move forward.

Full chamber action

When a committee recommends a bill favorably, house or senate leaders determine when (or IF) it will be placed on the agenda of the full house or senate for a formal vote. Lobbyists and bill sponsors are keys to leadership decisions in this regard. If no one is urging a full floor vote, the bill will most likely languish and ultimately die from inattention.

Votes by the full chamber or by committees or subcommittees do not occur randomly. Lobbyists (proponents and opponents) meet with legislators to determine their likely vote. If a bill is not likely to pass, it will be pulled from the agenda rather than risking a negative vote that effectively kills the proposal for the remainder of the current legislative session. A bill that has not been voted upon remains viable until the session is adjourned *sine die* (never to resume).

Bills may be amended on the floor as well as in committee or subcommittee. If a bill is approved it will either be referred to the other chamber to begin the process over again or, if both chambers have acted, go to the chief executive (president or governor) for signature.

When a bill passes one chamber and goes to the other, it is not unusual for changes to occur in the second venue. Even the smallest changes require the initiating chamber to concur. If agreement cannot be obtained, house and senate leadership name a conference committee. This committee considers both versions of the bill and makes recommendations regarding the final proposal. A conference committee report is prepared and voted upon by both chambers. Senators and representatives may vote only "yes" or "no" to accept the report. They may not amend it in any way.

Signature

The governor or president as chief executive of either the state or U.S. government respectively is charged with signing a bill into law. A bill may be vetoed or approved upon submission to the chief executive. The president may only veto a bill in its entirety. Governors in some states have what is known as line-item veto authority over certain pieces of legislation. That is, they can veto portions of a bill while allowing the remaining provisions to become law. Once signed, a bill becomes an "act" or the law of the land, effective either immediately if it has been declared an emergency proposal or within the number of days specified in the law itself, or within the time frame specified by the state's Constitution.

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The iceberg phenomena

Like an iceberg where much of the massive ice floe is hidden far beneath the surface of the water, the law making process is not always what it seems to be on the surface. Some may believe the process described above is set in stone—that all steps of the process must occur over a period of time, usually taking many months (or even years to complete). That is not the case, however. The entire process may be short-circuited when expediency demands. In other words, what you see may not always be what you get.

A moving bill may be amended to include language that lawmakers believe should be enacted without going through the tedious committee process. After a general election when a legislative session is winding down, the newly elected lawmakers or executive may have a different political philosophy or agenda than the current office holders. Consequently, there is considerable pressure to get the legislative agenda enacted quickly before the personnel changes take place. During this so-called lame duck session, bills are amended frequently often with little regard to subject matter relevance. Sometimes called Christmas tree bills these proposals are a conglomeration of selected provisions from multiple bills, some of which have stalled in committee and others that may have been introduced only recently. Regardless of the source, these bills are typically a potpourri of concepts that may or may not fit together coherently or logically. Following these rapidly changing measures poses many challenges for even the most veteran legislative watchdogs.

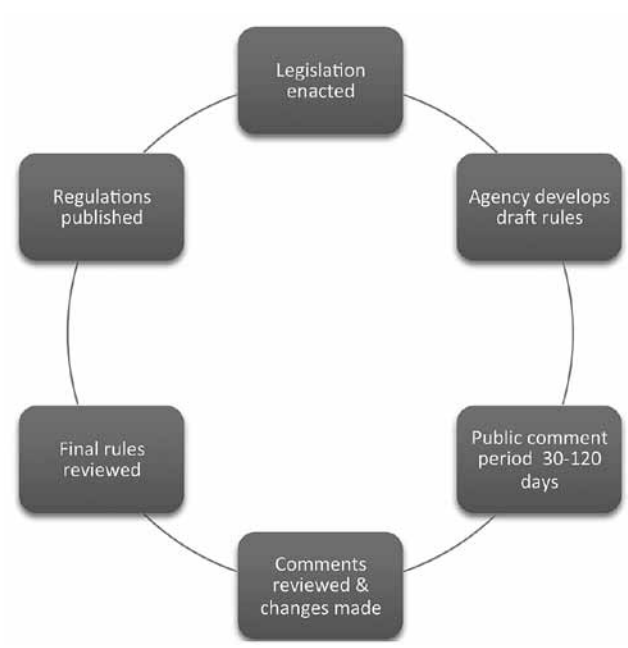
While the typical nurse may not be expected to know the details of the lame duck session, and all the deal-making that characterizes it, understanding that the phenomena exists is essential to effective advocacy. Time truly is of the essence in the waning days of Congress or state legislatures, which means getting a message to a law maker in a timely manner may require immediate targeted contact. For those not aware of this strategy, the process can pose significant challenges and frequent legislative surprises. Awareness of the phenomena, however, makes it a tool that can be used to one's advantage.

Rule making—the lifeblood of bureaucracy

As if law making were not enough, the executive branch of government (agencies such as boards of nursing, and departments such as Health & Human Services, the Environmental Protective Agency etc.) have been granted authority by the legislative branch to engage in rule making. The laws basically direct these agencies to adopt rules on specific issues. In other words the law tells affected parties what they must do and the agency's rules tell them how to do it. Typically, rules are more detailed than laws and must be adopted in accordance with the federal or state administrative procedures acts. Most importantly from an advocacy perspective, these procedures always include a public comment period. Generally, agencies heed what they receive from the public and make changes to the proposed rules before final filing takes place.

While some may believe it is the law that matters most, in reality, when properly enacted a rule has the force and effect of a law and is often where far-reaching policy decisions are debated and made.

Of particular significance when considering rule making is the fact that there is no time frame paralleling the two-year legislative cycle. In other words, agencies are constantly proposing rules for adoption, putting the proposed rule out for public comment (usually electronically) and seeking public input during a specified time period without regard for whether Congress is in session or pending adjournment.



Policy Process

Policy-making occurs in many venues both public and private. For purposes of this study public policy (laws and rules enacted by governmental entities) is the focus. However, the principles are largely the same whether policy is being made in the work place, by an organization, or by a legislative body.

"Policy is the deliberative course of action chosen by an individual or group to deal with a problem." (Mason 2012 p. 3) Policy-making entails choice. It is all about choosing between two or more options for dealing with an identified problem. Laws and rules are the ultimate reflection of the policy choices that are made, but how do people determine what those laws and rules should address?

The process has four discernible stages:

1. Problem identification or agenda setting
2. Development of the plan to solve the identified problem
3. Implementation of the plan
4. Evaluation

(Note the parallels between the policy process and the nursing process). The process is not linear nor is it an isolated exercise that takes place free from the dynamic forces that affect every facet of the overall system. Those forces include values, analysis & analysts, advocacy and activism, politics, media, interest groups, science & research, and presidential (or executive) power. (Mason. 2013).

To apply these concepts think about the enactment of the ACA and how these forces affected the ultimate legislation or policy options that were approved. While some may have preferred single payer universal health care, the forces at play dictated what was and was not possible to achieve.

ACA & Policy Forces

Values—small government, choice, independence, state's rights, limited taxes all shaped or limited policy options.

Media—emphasized the conflicts and protests; 24-hour news shows & multiple news sources—some reliable some not. Many had their own bias or prejudice that shaped public opinion and perceptions.

Interest groups—the medical association, nurses association, the pharmaceutical industry, hospital association, long-term care, health plans, and business interests were all at the table initially, but some distanced themselves when their members voiced loud opposition to the policy that was emerging. Reluctance to disturb the status quo was often paramount, especially for those benefitting from the current system. Keeping these interest groups neutral (or from becoming vocal opponents to the bill) led to many compromises.

Advocacy and activism—people rallied to oppose the law often without understanding the complexity of the health care system and the current reimbursement processes. Opposition was partisan, with the media focusing on the protests and angry responses across the country. Can we afford the new system? Will our value/preference for small government go by the wayside if the ACA is implemented? Proponents emphasized the lack of sustainability of the current system. "If something cannot go on forever it will stop." Stein's Law (Herbert Stein). What alternatives are possible?

Policy analysis—the cost of health care in the U.S. is not sustainable and the general outcomes are not reflective of the amount being spent. Many are uninsured and baby boomers are looming to create even greater demand on existing services. The current system pays for the wrong things, rewarding volume rather than quality. There is general agreement that the current system cannot continue unchanged.

Politics—opposition was loud and persistent. Passage of the bill was partisan creating dynamics that played out in the 2012 elections and various court decisions. Repeal and lack of acceptance of the law remain rampant. The U.S. House voted to repeal the ACA as late as May 2013.

Presidential power—President Obama made health care reform the cornerstone of his first term identifying it as the primary objective of his administration. The makeup of Congress allowed the bill to pass with no support from the Republicans setting up a political tsunami., that continues to cause backlash, unrest, and a lack of commitment to the complexities of implementing this complicated law. States are now the battleground as implementation moves forward. Whether to authorize Medicaid expansion or to administer the insurance exchanges required by the law are hot topics with significant long-standing implications.

Science & research—indicate that U.S. outcomes are not reflective of the amount spent on health care. We are not getting our monies worth. Many dollars are going to pay for preventable chronic diseases. There is a need to emphasize prevention and better care management of chronic diseases.

Nurses tend to get involved in the policy process at the implementation stage when not surprisingly the plan to be implemented may not be easily put into place nor will it work effectively to address the underlying problems. To be the most effective, the time to be at the table is at the agenda setting stage. How a problem is framed will determine the ultimate plan; therefore, framing the issue is critically important to the entire process. Nurses need to be part of those early discussions and debates.

Agenda setting,

As more individuals have health insurance coverage because of requirements in the ACA, access to care could be problematic. In fact people in policy-making roles have recognized that there are not enough primary care providers to meet the anticipated demand. This problem can be framed in one of two ways—we need more primary care physicians to meet the need OR advanced practice registered nurses must be allowed to practice to the full extent of their education and training. Obviously, the way the problem is characterized or framed will dictate the policy solutions adopted to address the access void. How can the problem be framed to help ensure a stronger nursing presence in the programs developed to fill the identified void?

A further example of agenda setting can be seen in conjunction with the tragic school shootings that occurred in December 2012 in Sandy Hook, CT. Immediately following the shooting many advocacy groups began to opine about what must be done to prevent similar tragedies in the future. Briefly, there were several options vying for the policy spotlight—better mental health care for young people; a ban on assault weapons/background checks to ensure guns are not available to those who should not have them; and finally regulating video games so as to minimize young peoples' exposure to the violence depicted in them. Quickly, the policy forces (values, interest groups, the president, and politics) combined to turn the debate into a conflict between those who wanted a measure of gun control and those who believed even the smallest amount of regulation of gun sales would violate the 2nd Amendment of the U.S. Constitution. Mental health issues and video game violence became non-factors and were subsumed by the loud debate on the emotional gun control issue. Policy solutions followed suit.

Planning

Once the policy issue is on the agenda, policy-makers may have multiple possible solutions to propose. As the debate moves forward, it becomes apparent how various policy forces will limit the viability of certain programs or options. Enforcement considerations can also pose challenges. Will the policy be enforced by imposing a penalty for non-compliance (the stick approach) or will compliance be encouraged via rewards (the carrot approach)? If there is to be a penalty, what should it be, and who will enforce it? If a reward approach is adopted, how will that be administered? What source of funds will be tapped to provide the incentive? Policy-makers may decide to forego both the carrot and stick approaches believing that compliance will occur once the public is sufficiently educated regarding its benefits.

All enforcement tools have inherent limitations, and political considerations often dictate the approach taken. Frequently, opponents can be convinced to remain neutral when proponents agree not to include penalty language in the bill. Getting a measure through the legislature, even an imperfect something, can be viewed as a victory that may pave the way toward more extensive action at a later date.

Public policy around obesity

How to address the increasing prevalence of childhood obesity challenges policy-makers. Is it enough to educate mothers (caregivers) about the inherent health implications of childhood obesity, or is a different approach needed? Should access to unhealthy foods (sugar-sweetened soft drinks) be limited? Should healthy food choices be rewarded? What barriers deter these choices? How can those barriers be overcome? Merely identifying a problem is not enough. Policy-makers also need to be made aware of possible solutions.

Implementation

Merely enacting a law or initiating a policy change is only the beginning. Moving from concept to reality carries its own set of challenges. When a measure is passed without widespread support, opponents may use the implementation phase to erect roadblocks that can effectively stall any and all progress. (The ACA is an excellent example of this strategy in action). One of the most effective tactics is to generally limit or refuse to appropriate the funds needed to get the program up and running. If necessary funds are not available, the intended policy change may move forward slowly, if at all. Proponents who argued the merits of the change in the legislature, consequently, are unable to point to the predicted successes, which can hamper their efforts in the future to expand or enhance the programs at issue.

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Even when a policy has broad support, implementation may be slowed simply because critical logistics have not been well thought-out. If the people charged with making programs work are not able to grasp the intent of the policy-makers, the implementation efforts may stray far from the original intent, which creates its own set of problems. For these reasons, it is important for nurses to be engaged throughout the policy-making process rather than solely when it is time for implementation to begin. An implementation reality check should occur when agenda setting and planning processes are on the drawing board. If a policy, as envisioned, cannot be implemented, that fact should be made known during the formulation stages. Again, nurses' contributions would be invaluable.

ACA implementation

States are the implementers of many of the provisions of the ACA. If state officials want to send a message to Washington signaling continuing opposition to the law, they can enact policies or adopt tactics that impede smooth implementation. For example, the ACA relies on state-based insurance exchanges to provide qualified individuals a marketplace for purchasing affordable health care insurance coverage when the individual mandate becomes effective in 2014. When states opt out of administering the programs, they force the federal government to shoulder the entire administrative burden of the exchanges, which may strain financial and human resources and ultimately force a return to the policy drawing board.

Evaluation

To determine whether a policy change is working effectively, there should be some evaluation of the outcomes. Occasionally, the legislation that creates the change includes expectations regarding the evaluation. Pilot programs may be authorized with built-in criteria to be addressed and reported on before the program is replicated on a broader scale.

Even without a formal evaluation, policy analysts and those who are the intended beneficiaries of a program are good resources for determining the effectiveness of a particular policy. Is it reaching the intended target? Is the program affordable from a cost benefit analysis perspective? Is the change envisioned by the program being realized? These are the questions to which policy-makers may seek answers before being convinced that further change is warranted.

Nurses are frequently charged with the evaluation responsibility. Developing appropriate evaluation tools that measure outcomes fairly can be challenging, especially when those invested in the program have a lot at stake in the evaluator's findings. The most effective evaluators are those who have a firm grasp of both the policy being analyzed and the process undertaken to achieve policy enactment.

Attention to People—it truly is who you know

Certainly knowledge of the legislative/regulatory process is important, but success in the policy-making arena is equally all about relationships—who trusts whom; who can influence; who can manipulate; who knows whom. Studying the personnel is key to the preparation athletic teams go through before a game. They watch endless game film to identify their opponents' patterns. What are their weaknesses, their strengths? Entering a game without that preliminary preparation virtually guarantees a losing effort. That same level of preparation ought to be part of any legislative endeavor.

Who you should know

First and foremost, nurses should know the identity of their federal and state representatives and senators. While some may know their congressman or U.S. senator few can name their state representatives. Although federal lawmakers are important, state lawmakers have a greater impact on everyday nursing interests; therefore, knowing who they are is an essential first step These individuals are often more accessible, than their federal counterparts regularly conducting meetings with their constituents in local libraries and restaurants. State government websites are good sources for the needed information. Not only do these sites identify the individuals, they also include biographical information and photographs that enable their constituents to readily identify them.

When a nurse or an organization has an issue that needs legislative attention studying the personnel is step one. In making this preliminary and ongoing assessment one should of course consider the leaders. That means looking not only at the recognized leaders (the individuals elected by their peers to be Speaker of the House, President Pro Tem of the Senate and party whips) but also at those who exercise influence over their colleagues by virtue of their expertise or experience with certain issues.

A lawmaker with health care experience (a nurse, physician, or pharmacist for example) will often be considered the go-to expert by his/her peers in the legislature. It is therefore important to at least touch base with these individuals so they are not taken by surprise when an issues surfaces. In addition, some lawmakers make health care their priority and tend to be looked to as resources for health care related measures. They too need to be kept in the loop as issues evolve. Finally, it is important to ascertain how much lawmakers in general know about the particular issue that is the subject of the pending bill. For example, if a proposal were being introduced that recognized nurse practitioners as primary care providers for purposes of leading patient-centered medical homes, proponents would need to know whether lawmakers understand the education and preparation of advanced practice registered nurses as well as what they know about the overall medical home concept. If they do not have background information, educational efforts must begin with the basics.

Getting a lawmaker's attention

Busy lawmakers seldom have time to read in-depth multiple page documents no matter how sound the information or how impressive the research findings. Brevity is key. Summarizing the key points of an issue—the so-called one-pager or leave behind—increases the likelihood a legislator will actually read the information provided. Professional jargon should also be kept to a minimum.

It is not enough to only know the elected representatives. Other individuals also play important roles in the success or failure of any legislative initiative, and their contributions should not be ignored or minimized. Most lawmakers have aides who assist them in many significant ways. These aides are often the trusted eyes and ears of their bosses. They frequently meet with constituents and are able to devote more time to a particular issue than the legislator who has multiple competing interests vying for his/her attention. Savvy lobbyists and advocates know the value of keeping the legislators' staff members well informed and in the loop regarding both the substance of an issue as well as other factors that may affect its progress. Nurses who find themselves meeting with a legislative aide should take full advantage of the opportunity and cultivate that connection for the future. Always provide materials about an issue to both the legislator and his/her aide. Purposefully, include aides in the discussions, respectfully recognizing the key role they play.

Executive branch agencies (the rule makers) employ many individuals who have specific expertise around certain issues. These bureaucrats often have a long history that predates legislators and their staff members. They know why an issue failed, who opposed it, the strategies used, and many other salient details. Making connections with these individuals can be extremely helpful, not only because their knowledge cannot be dismissed, but also because they can be encouraged to take advantage of the nurse's expertise when drafting rule language and other policy documents. Input at this crucial initial stage is often more valuable than trying to change the language once it is proposed.

Attention to Politics—the elephant in the room

Process and people do not exist in a vacuum. For better or worse, neither can be separated from the political considerations that characterize both the public and private policy-making worlds. "Intrigue," "expediency," "control," "sinister," "contrived," "opportunistic," "dirty" are a few negative connotations associated with politics. In actuality, politics is neither negative nor positive. It is merely the process through which people make decisions that form the basis for the authoritative allocation of values. Through politics, decision-makers determine with authority that gets what. Workplace politics often determine who gets what office, the plum work assignments, and even coveted promotions. The underlying dynamics of the political game are the same regardless of the setting in which it is being played.

Despite its inevitability, politics is the proverbial elephant in the room, often being cited as the reason people (nurses) do not want to participate in the law and rule-making activities. Before so readily opting out of the policy-making arena, however, nurses should look more closely at what that means for their professional practice and consider how they can play the political game without compromising the public trust or their own core values.

Admittedly, playing the political game in the legislative arena is not for the faint of heart. Politics is rooted in power, and that can be a deterrent for many nurses who are reluctant to embrace some of the most obvious power elements associated with lawmaking. The role of money and the amount of it that changes hands is one of the most troublesome aspects of lawmaking, often cited as the reason why nurses and others refuse to engage in political advocacy.

While money is important, it is not the only source of political power. Numbers can be equally influential, and nurses as the largest segment of the health care workforce have numbers others can only envy. These numbers give nurses an enviable source of potential power that cannot be readily duplicated Making those numbers work is a major challenge facing those who advocate on behalf of nursing's professional interests.

As a profession, nurses readily divide themselves according to their specialty areas of practice. "I'm a school nurse." "I work in oncology." "I work in the OR." "I'm a staff nurse." "I'm a nurse practitioner." If the issue does not affect one's practice directly, nurses generally will not become involved in it. As a result, when three million nurses could be communicating with their elected officials, only the thousands directly impacted by an issue send messages. The real extent of nursing's power base goes unrecognized and untapped and success in the legislature is diminished.

Characterized as a "sleeping giant," nursing's power would be enhanced ten-fold if its practitioners could come together cohesively to advocate as a unit without regard for practice specialty, educational preparation, or union affiliation. Nursing's lack of unity is fostered by those groups with interests that are best served by keeping nurses off balance. Subtly emphasizing divisive differences within nursing allows rival groups to enhance their own power positions at nursing's expense. Until nurses refuse to fall into that trap they will continue to face unnecessary obstacles in achieving their legislative goals.

Attention to perceptions

The cliché, "a picture is worth a thousand words" holds true in the policy-making arena. While advocates may produce mounds of evidence supporting a particular position, lawmakers' personal connections remain a powerful force that words cannot always overcome, especially if the message being conveyed is inconsistent with personal perceptions.

Most legislators know a nurse and many have nurses as family members. Despite these connections a legislator's knowledge of nurses and nursing practice may be based on out-dated or incorrect information. Further, if the media were the primary sources of lawmakers' understanding of the role nurses play in health care delivery, it would not be a surprise if they believe nurses make few if any decisions regarding a patient's health status or outcome. Further, if a lawmaker has a positive or negative personal experience with a nurse, that experience is likely to be generalized and color his/her perceptions of nurses and/or their practice.

Perceptions at work

A legislator watched the care her mother received in a long-term care facility and noted that nurses were not administering medications to the residents. They merely left a cup of pills in the room and exited as quickly as possible. Later, when a proposal surfaced in the legislature to authorize unlicensed individuals to administer medications in these settings, the legislator could not be convinced that resident safety was jeopardized by the change. Nurses argued that the pre-administration assessments they performed were essential to the residents' safe care; however, that contention was not supported by the actual practice experienced by the legislator. In her experience nurses were not performing those assessments so the change was merely codifying existing practice. No amount of advocacy could alter her perceptions, and her voice carried significant weight with her colleagues.

Because these personal experiences can be difficult to overcome, to make inroads requires acknowledgement of the validity of the experience while bringing other evidence to the table in an attempt to temper or counteract it. One strategy would be to invite a lawmaker to shadow a nurse constituent at work. Having them see first-hand what nurses do can make a lasting powerful impression.

More about perceptions—a different perspective

Nursing remains primarily a female-dominated profession even though the number of males has been increasing. Consequently, some of the lessons learned through childhood games are played out in the policy-making world where men's rules dominate. Boys through their team sports learn to understand competition, winning, hierarchy and how to lose and move on. Girls, on the other hand typically form strong small alliances that emphasize non-verbal communication, collaboration, and friendships. Women focus first on process—making sure everyone has his/her say before making decisions about more controversial substantive issues. Men are more directly goal driven with many of the most critical issues decided before the actual meeting ever occurs. Women are less comfortable playing with people they do not like and tend to carry the meeting dynamics with them afterwards. They are less willing to accept that when the game is over it is over with all that went on during the game/meeting forgotten. These dynamics if not recognized tend to hamper some nurses' advocacy efforts. Although it may not be possible to change one's basic approach to these interactions, recognizing the gender differences can help women increase their effectiveness in the policy-making game.

Legislators frequently remark that nurses do not show up. That reputation makes it easier for policy-makers to give short shrift to nurses' legislative agenda, especially when other competing interest group are in opposition or are making noisy demands regarding their own initiatives.

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The ABCs of Effective Advocacy continued from page 10

A graduate nursing student attended an interested parties meeting in a legislator's office where various interest groups were invited to come together informally to discuss their concerns about a scope of practice bill that would have expanded one discipline's authority with respect to prescribing medications. After listening to all participants the student observed that group A was "too nice." They were too willing to make accommodations. Group B was more demanding and its position seemed unwavering. While its demeanor was more aggressive, Group B also came across as more self-assured and confident in the correctness of its arguments. Such perceptions often make the difference between success and failure. Nurses often find themselves in the group A category when the group B approach would serve their interests better.

Nurses need not compromise their integrity to be effective in the legislative arena. By speaking with a consistent voice with patience, passion, and perseverance, legislators will get the message that nurses are not going away nor are they willing to sit by and watch their initiatives go unheeded. Changing perceptions can be time-consuming but worthwhile in the long run. The first step is recognizing the importance of perceptions and the need to make changes.

Bipartisanship

The political game, and it is truly a game, is a marathon not a sprint; therefore, taking a long-term view is essential for prolonged success. That means developing relationships and connections that span political parties, election results, and other partisan considerations. Those who recognize the long-term nature of the game will develop sustainable relationships that span legislative sessions and election turnarounds.

Politics does indeed make strange bedfellows. Today's opponent may be tomorrow's sponsor of your key bill. One cannot afford to make enemies on one side of the political aisle or the other. While one political party may hold a seemingly insurmountable majority today, election results could completely change control of the house, senate, and executive branch in the future thus making previous alliances essentially meaningless.

Members of the nursing profession are not homogenous in their political beliefs or philosophies. Rather than being identified or aligned with one party or the other, nursing's larger interests are best served by maintaining positive relationships with both political parties. That means respecting members on both sides of the aisle and keeping the lines of communication open even when engaging in more overt political activities such as candidate endorsements and political contributions.

Collaboration

As noted previously, unity among nurses would enhance the overall effectiveness of the profession's advocacy efforts. Because numbers can be powerful influencers over public policy decisions, building coalitions between nursing groups and others can be yet another strategy for ensuring that advocacy efforts are even more powerful than they otherwise might be. These collaborations while positive in many respects are not without challenges, however.

In order to increase the likelihood of success, a collaborative effort must overcome several obstacles—both tangible and intangible. Typically, people (interest groups) find they have a shared interest in a particular issue and agree that working together would be mutually beneficial. At that point, efforts begin to put together a coalition, often without sufficient attention to key details.

To be a truly effective collaborative several issues must be addressed. They include:

- Having the right people at the table—people who can speak for the organizations they represent and who are committed to the level of participation required by the circumstances.
- Agreeing on how the group will function. Will processes for decision-making be formal or informal? How will consensus be reached? What constitutes agreement? Who will speak for the group? Too much process can stymie progress and make the quick action often required in a policy-making endeavor impossible to achieve.
- Recognizing that there may be a level of mistrust among participants based on previous interactions. These dynamics, if not acknowledged, will make it difficult to reach any meaningful level of consensus within the coalition.
- Turf battles are another reality that can hamper effectiveness. For some groups, getting credit for outcomes is critically important so control over the processes becomes an issue that can ultimately doom the effort.
- Too much planning, too many meetings and too few resources deter and discourage even the most ardent supporters. Few coalitions can survive without resources, but nurses often pride themselves on their ability to make something out of nothing. While that may be admirable, in reality it is a guaranteed road to frustration and failure.
- Communicating within the coalition and outside of it must be carefully considered. Who will speak for the group and what will the message be? How will members of the coalition be kept informed of developments?

Because of the value a collaborative effort can have, overcoming the challenges is often well worth the effort. With planning and attention to possible pitfalls from the outset an effective coalition can be built and sustained.

Conclusion

Nurses who want to make a difference for their profession and ultimately for their patients need not be intimidated by the idea of advocacy in the policy-making arena. Several relatively simple steps provide a roadmap to success.

- Accept the obligation to be involved, at least to some extent. Involvement need not be a full-time job, but it is also not an option.
- Connect with a nursing organization to build networks and stay informed. Policy-making is often time sensitive and always dynamic. While employers may be good resources for information, always look elsewhere for additional perspectives to make sure you have the fullest picture possible of the issues.
- Share information with colleagues. Your enthusiasm could be contagious and influence others to also get involved.
- Recognize you are the boss—elected officials work for you. Many have very little in-depth knowledge about nursing and health care delivery so you are the expert. They need you!
- Vote for those who will be representing you in congress, at the statehouse, and on school boards and city councils. AND vote knowledgeably.
- Reach out to your own legislators at the local, state and federal levels. Know who they are and offer your considerable expertise to help them understand some of the complex issues they must deal with around health care.
- Use the skills that are the foundation of nursing practice—communication in difficult circumstances and a knack for education—in the advocacy arena.

Remember, "Those who refuse to participate in politics shall be governed by their inferiors"--Plato

Free Medicare Counseling

We're pleased to announce a new Ohio Nurses Association new member benefit to help those of you approaching 65 or actively in retirement choose the best available Medicare plan.

Choosing the right Medicare plan can be quite confusing and a bit overwhelming. With that in mind, ONA recently joined forces with Seniority Benefit Group (SBG) SBG's program, **Medicare-Connect**, helps members sort through options for Medicare Supplements, Medicare Advantage and Prescription Drug Plans via one-on-one counseling. SBG will also provide year-round support for claims questions and annual reviews. Best of all – this service is free to ONA members.

Seniority Benefit Group is a Central Ohio-based company that assists over 3500 seniors throughout Ohio. "Simply put, we help seniors fight the right Medicare Plan that fits their needs and budget," says Scott Miller, SBG's President and Founder. "Choosing between Medicare plans can be a difficult process and can change from year to year. Our service is free of charge to members who can get advice from a source that has their best interest in mind" added Miller.

SBG helps seniors pick from plans offered by United Healthcare, Anthem, Aetna, Mutual of Omaha, and Humana.

"Generally speaking, we help people when they are turning 65, retiring from work or during the Fall open enrollment period," said Josh Kinzel, a SBG representative.

Turning 65 – Members turning 65 can reach out to Seniority Benefit Group six months prior to their birthday to begin researching options and estimated costs. Enrollment can begin three months prior to a members' 65th birthday month.

Retiring Post 65 – Many people continue working after turning 65 and stay on a group-sponsored health plan. When they retire, it is often necessary to find a Medicare health plan to help supplement out of pocket costs. It is recommended that individuals considering retirement contact Seniority Benefit Group at least 3 months prior to their target retirement date.

Annual Fall Open Enrollment – Each year, Medicare-eligible individuals can review their plan during the Fall Annual Election Period. During this time, seniors can enroll or change their Medicare Advantage and Prescription Drug Plans. This year, open enrollment will be October 15th thru December 7th. Members can contact SBG beginning on October 1st to discuss options.

To schedule a private, no-cost consultation, contact Josh Kinzel at (855) 402-8820 ext 225 or email Josh at kinzel@sbg65.com. For more information about Seniority Benefit Group, visit their website at www.SBG65.com.

The ABCs of Effective Advocacy: Attention, Bipartisanship, & Collaboration

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:_____

Date:_____ **Final Score:** _____

Match the following terms with the correct definition.

TERMS

1. Christmas tree bill: _____
2. Advocacy: _____
3. Politics: _____
4. Legislators: _____
5. Legislature: _____

DEFINITIONS

a. Individuals who are authorized to make laws.
b. Process through which people make decisions with authority to determine who gets what.
c. A tactic for getting issues addressed legislatively in the waning days of a legislative session.
d. The entity authorized to engage in lawmaking.
e. Seeing a need and finding a way to address it.

6. A new session of Congress began in January 2013. A bill introduced into the Senate must pass the Senate by December 2013 or be re-introduced in 2014.
   a. True
   b. False

7. A nursing organization has convinced a legislator to have a bill drafted that would eliminate mandatory overtime as a routine staffing strategy in acute care hospitals. In the first version of the bill hospitals that did not comply faced a $10,000 penalty per violation. The policy maker is relying on the _____ approach as an implementation/enforcement tool to encourage compliance.
   a. Stick
   b. Carrot

8. In identifying potential sponsors for the mandatory overtime prohibition bill which of the following would be important considerations?
   a. Party affiliation with members of the majority party being more likely choices
   b. Legislator A is a member of the standing committee to which the bill is likely to be referred.
   c. Legislator A has sponsored multiple health care bills and is recognized as having expertise on the subject by his peers.
   d. All of the above
   e. b & c only

The mandatory overtime prohibition bill has been and will be affected by policy forces. Match the force with its effect.

9. Interest group: _____
10. Scientific research: _____
11. Politics: _____
    a. There is some evidence to show working excessive hours affects one's judgment & ability to make critical decisions resulting in medical errors
    b. The organization opposing the bill has encouraged its members to contact legislators to express serious concerns about how the bill ultimately will affect the local hospital's profitability and economic viability. The hospital is one of the major employers in many legislative districts.
    c. It is an election year and opposition to the bill has been very vocal. Maintaining majority control is at stake in the election & could easily swing to the minority party. Therefore it is important not to upset key supporters.

12. A bill becomes a law upon signature by the president even if the Senate has refused to concur with changes made by the House of Representatives.
    a. True
    b. False

13. The stages of the policy process include:
    a. Agenda setting, intervention, revision, & public comment
    b. Problem identification/agenda setting, planning, implementation, & evaluation
    c. Introduction, committee action, vote by the legislature, & signature of the president or governor
    d. Critical thinking, hearings, revision, evaluation

14. The legislative branch of government is the only branch with authority to make public policy.
    a. True
    b. False

15. Once a bill is enacted, supporters of the legislation can be assured that the policy will be implemented as intended.
    a. True
    b. False

16. Agencies with rule making authority can propose new and revised rules without regard for the two-year legislative cycle that governs activities within the legislature.
    a. True
    b. False

17. A lawmaker has noted that many of the teenagers in his daughter's class at school are overweight, bordering on obese. He asks for a meeting with a family friend who is also a school nurse to discuss his concerns. The nurse prepares for the meeting but upon arriving at his office learns that she will be meeting with the legislative aide rather than her friend. The nurse should:
    a. Politely refuse to meet with the aide because she was prepared to meet with the legislator, and the aide will not understand the points she wants to make.
    b. Ask the aide to re-schedule the meeting for a time when the legislator is able to attend.
    c. Provide the aide with the materials she has prepared and discuss the pros and cons of developing public policy to address the problem.
    d. Meet with the aide to let him know how upset she is that the legislator is not available emphasizing how much time she spent preparing for the meeting.

18. Because politics is a power game that nurses are not well equipped to play, they may refuse to be involved in any public policy-making activities.
    a. True
    b. False

19. Developing collaborative relationships can enhance the likelihood that a policy initiative will be successful; however, effective collaboration requires all but the following:
    a. Agreement as to how the group will function and make decisions
    b. Resources sufficient to support the work of the collaborative
    c. Having people with decision-making authority at the table
    d. Frequent meetings to make sure everyone is kept abreast of all developments.

20. A single party holds a strong majority in both the senate and house and also controls the executive branch. Several legislative initiatives are enacted that a nursing organization adamantly opposes. The organization is considering sponsoring a series of televised ad spots ridiculing targeted lawmakers in the majority party. The organization should recognize:
    a. Lawmakers do not pay attention to these sorts of ads so there will be no repercussions.
    b. The ads will ensure the offending lawmakers are not re-elected thus changing the balance of power in both the legislative and executive branches of government.
    c. The ad campaign may backfire thus making it more difficult for the organization to get its legislative initiatives addressed.
    d. Lawmakers will understand the organization's concerns and take steps to revise the offending initiatives.

21. The agenda setting phase of the policy process is the point where a problem is framed or defined thus setting the stage for how the policy will be shaped.
    a. True
    b. False

22. Because the Affordable Care Act was enacted without bipartisan support its implementation has met with several obstacles including:
    a. Law suits challenging the constitutionality of various provisions in the Act
    b. Refusal by some states to agree to take on administrative responsibility for the insurance exchanges that must be in place by 2014.
    c. Inadequate appropriation of the funds needed to fully enforce certain provisions of the Act
    d. None of the above
    e. a, b, & c.

23. Policy evaluation is undertaken to determine whether a program is working effectively and may include:
    a. Cost benefit analysis
    b. Pilot programs with built-in criteria that shape the analysis
    c. Determinations as to whether the changes envisioned are being realized
    d. Analysis as to whether the program is reaching its intended target
    e. All of the above
    f. All except b

24. The legislative process can never be short-circuited for expediency purposes because doing so violates the federal and state Constitutions.
    a. True
    b. False

25. When a bill is introduced into the House of Representatives or Senate it will be numbered sequentially and will maintain that same number throughout the process.
    a. True
    b. False

Evaluation

		YES	NO
1.	Were you able to achieve the following objectives?		
	a. Discuss the Patient Protection and Affordable Care Act (ACA).	___Yes ___Yes	___ No ___ No
	b. Describe the legislative process.	___Yes	___ No
	c. Describe the policy process and how it relates to ACA.	___Yes	___ No
	d. Identify the various ways in which nurses can be politically involved.	___Yes	___ No
2.	Was this independent study an effective method of learning?	___Yes	___ No

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____

4. What other topics would you like to see addressed in an independent study?

Standards of Practice and Delegation for Nurses Licensed to Practice in Ohio

Developed by: R. Wynne Simpkins, RN

This independent study has been developed for nurses who wish to learn more about Chapter 4723-4 and 4723-13 of the Ohio Administrative Code (OAC) and how it relates to their nursing practice.

1.5 contact hour of Category A (Law and Rules) will be awarded for successful completion of this independent study. The author and planning committee members have declared no conflict of interest. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

OBJECTIVES

1. List at least two differences in the scopes of practice for RNs and LPNs in Ohio.
2. Discuss standards of nursing practice for all nurses licensed in Ohio.
3. Discuss delegation principles for use by nurses as outlined in the Ohio Administrative Code.

STUDY

As a nurse licensed in the state of Ohio, you must practice within the parameters set by the Nurse Practice Act, also known as Chapter 4723 of the Ohio Revised Code (ORC). That law was written by the legislators, members elected by Ohio's citizens to the State Senate and House of Representatives, who make up the Ohio General Assembly. Rules that further define the respective practices of every nurse in Ohio, whether a licensed practical nurse (LPN), registered nurse (RN), or advanced practice nurse (APN) [may also be referred to as an advanced practice registered nurse (APRN), are written by the members of the Ohio Board of Nursing (OBN) with input from other nurses and interested parties across the state. The Rules, found in Chapter 4723 of the Ohio Administrative Code (OAC), are derived from the ORC (law). The rules help nurses understand the standards to which they are held by the licensing body, the OBN.

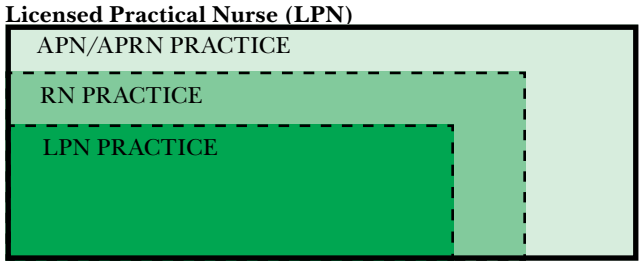
This learning activity will cover the scope of practice for each level of nurse licensure recognized in Ohio, then take the learner through the legal standards of practice and delegation standards as found in the respective chapters of the OAC. As used in this learning activity, as in the ORC and OAC, the term "Nurse" is a generic term depicting all individuals who hold a current and valid license to practice as an LPN, RN or APN/APRN in Ohio.

Nursing Scope of Practice

The scopes of practice for RNs and LPNs are outlined in the very first section of the law, Section 4723.01 ORC, the definitions section. The various types of APNs/APRNs are defined in Section 4723.01 ORC, but the respective scopes of practice for each type or specialty area, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, Certified Nurse-midwife, and Certified Nurse Practitioner, are located in Section 4723.43 ORC. Each scope of practice will be discussed briefly, since all nurses are expected to understand the respective scopes of practice for individuals involved in the health care team. More specifically, this learning activity will discuss the scopes of practice of nurses involved in the health care team. Additionally, the scope of practice is the basis for all relevant rules that impact nursing practice in Ohio.

The nurse's scope of practice applies at all times when the nurse is engaged in the practice of nursing, whether as a volunteer or for pay, regardless of the setting in which the nursing care is delivered. With all of the various levels of nurse licensure, the limits set on each can sometimes be confusing. Perhaps it would be helpful to consider all of nursing practice as one unit (see Figure 1) within which we are all working to provide nursing care for the health care consumer in Ohio. Nurses that hold each level of licensure are educated appropriately for that level of licensure. The LPN is provided a basic nursing education over the course of approximately one year of full time study, and has a narrow scope of practice. The RN is provided a greater breadth and depth of knowledge base initially because RN education takes place over at least two academic years of full time study, resulting in a scope of practice with greater depth and breadth than the LPN. Then the APN/APRN must hold at least a Master's degree **AND** certification in a nursing specialty area, which means the APN/APRN has the largest scope of nursing practice. When considering the length of time each is enrolled in school, studying the human body, its limitations, disease processes, and the various remedies and associated nursing care, it is easier to understand the breadth and depth of the scope of practice for each level of nurse licensure. Please bear in mind however, that in the model depicted in Figure 1, the parameter for each level is left open allowing the APN/APRN to perform any level of nursing care/task that may be performed by an RN or LPN in Ohio. The RN may perform any nursing care/task that may be performed by an LPN. No one may practice outside of their respective legal scope of practice, but may work within that scope provided the nurse follows the legal standards of care and delegation standards that are outlined in Chapters 4723-4 and 4723-13 OAC respectively.

Figure 1. NURSING PRACTICE IN OHIO



The LPN is considered a "dependent practitioner" because the LPN practice is to be directed or guided by another licensed health care practitioner such as a:

Registered Nurse;
Physician;
Dentist;
Podiatrist;
Optometrist; or
Chiropractor;

> The LPN is considered a "dependent practitioner" and provides nursing care that requires the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences.

The LPN provides nursing care that requires the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences. That care includes:

(1) Observation, patient teaching, and care in a diversity of health care settings;
(2) Contributions to the planning, implementation, and evaluation of nursing;
(3) Administration of medications and treatments…;
(4) Administration to an adult of intravenous therapy… on the condition that the licensed practical nurse is authorized … to perform intravenous therapy…;
(5) Delegation of nursing tasks as directed by a registered nurse; and
(6) Teaching nursing tasks to licensed practical nurses and individuals to whom the licensed practical nurse is authorized to delegate nursing tasks as directed by a registered nurse. [Section 4723.01 (F) ORC]. (129th General Assembly, 2013)

Registered Nurse (RN)

RNs are responsible for "providing nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences." The RN has five independent functions and one dependent function:

(1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;
(2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;
(3) Assessing health status for the purpose of providing nursing care;
(4) Providing health counseling and health teaching;
(5) Administering medications, treatments, and executing regimens…; and
(6) Teaching, administering, supervising, delegating, and evaluating nursing practice." [Section 4723.01 (B) ORC] (129th General Assembly, 2013)

> RNs are responsible for "providing nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences."

Advanced Practice Nurses (APN/APRN)

APN/APRN is an umbrella term that includes the certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, and certified nurse practitioner. Before an individual may apply to the OBN for a certificate of authority, commonly referred to as a COA, to practice in the capacity of an APN/APRN, the individual must first be a registered nurse. Therefore, the APN/APRN may also direct the practice of the LPN in Ohio and is held accountable to the same legal standards of practice and delegation standards as any other RN in Ohio. Some APN/APRNs, such as CNPs, CNSs, and CNMs, also have earned a certificate to prescribe (CTP) which permits them the ability to prescribe medications and therapeutic devices. Other nurses may accept valid orders from APN/APRNs for medications and therapeutic devices, provided the APN/APRN is the holder of a current valid CTP. As with all other nursing licenses, information about the APN/APRN with a CTP may be found on the State of Ohio e-licensure web site at https://license.ohio.gov/lookup/default.asp?division=86.

Certified Registered Nurse Anesthetist (CRNA)

CRNA in Ohio, "with the supervision and in the immediate presence of a physician, podiatrist, or dentist, may administer anesthesia and perform anesthesia induction, maintenance, and emergence, and may perform with supervision preanesthetic preparation and evaluation, post-anesthesia care, and clinical support functions." [Section 4723.43 (B) ORC] (129th General Assembly, 2013)

Clinical Nurse Specialist (CNS)

The CNS in Ohio works "in collaboration with one or more physicians or podiatrists, may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the nurse's nursing specialty, consistent with the nurse's education and in accordance with rules adopted by the board." [Section 4723.43 (D) ORC] (129th General Assembly, 2013)

"When a clinical nurse specialist is collaborating with a podiatrist, the nurse's scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform." [Section 4723.43 (D) ORC] (129th General Assembly, 2013)

Certified Nurse-midwife (CNM)

A CNM in Ohio may provide for the "management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically," but may not perform "version, deliver breech or face presentation, use forceps, do any obstetric operation, or treat any other abnormal condition, except in emergencies." [Section 4723.43 (A) ORC] (129th General Assembly, 2013)

Certified Nurse Practitioner (CNP)

The CNP in Ohio, "in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the board." [Section 4723.43 (C) ORC] (129th General Assembly, 2013)

"When a certified nurse practitioner is collaborating with a podiatrist, the nurse's scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform." [Section 4723.43 (C) ORC] (129th General Assembly, 2013)

Determination of Death-Section 4723.36 ORC

An RN may determine and pronounce an individual's death if the nurse is providing or supervising the nursing care of the individual through a licensed hospice care program or an entity that provides palliative care and the respiratory and circulatory functions of the individual are not being maintained artificially at the time determination and pronouncement of death are made.

A CNS or CNP may determine and pronounce an individual's death if the nurse is providing or supervising the nursing care of the individual through a licensed hospice care program or an entity that provides palliative care and the respiratory and circulatory functions of the individual are not being maintained artificially at the time determination and pronouncement of death are made. Additionally, the CNS and CNP may determine and pronounce death in a:

- Licensed nursing home;
- Residential care facility or home for the aging; or
- A county home or district home.

> **Look up an Ohio nursing license at** https://license.ohio.gov/lookup/default.asp?division=86.

The RN, CNP or CNS may determine and pronounce death, but may not complete any portion of the individual's death certificate, and must notify the individual's attending physician to allow the physician to fulfill their duties to the individual (129th General Assembly, 2013).

Standards of Nursing Practice-Chapter 4723-4 OAC

Some nurses in Ohio think that the standards of care are different for them because of where they work. In some respects, that is true. For instance the frequency with which a nurse checks the vital signs and overall patient condition will be different in an intensive care unit than in home care. However, the difference between these settings is not that the nurse is held to a different standard, but that the patient in each setting has different care needs. Specific

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standards tend to be directly related to the acuity level of client care that is generally anticipated for the setting. Should a patient in home care present with a sudden change in condition or emergent symptoms, the nurse is expected to respond accordingly. The OBN, in their infinite wisdom understood the differences in care settings and acuity levels and set out to write a set of rules that would apply to all nurses in Ohio regardless of work setting.

Standards of Nursing Practice for Ohio are found in Chapter 4723-4 OAC, the rules which outline *legal standards of practice*. Basically, all nurses licensed in Ohio, regardless of scope of practice, are held to similar standards with respect to competent practice and patient safety. Each nurse is responsible for practicing competently and consistently according to the standards for the practice area in which the nurse is engaged and within the respective scope of practice for which the individual nurse is licensed, i.e. LPN, RN, or APN/APRN. The standards of Nursing Practice, (4723-4 OAC) (Ohio Board of Nursing, 2010) are printed in their entirety for reference purposes at the end of this activity.

The standards are divided into care related to competent practice as an LPN, RN, or an APN/APRN. These standards are very similar for each level of licensure, with specific attention to the respective scope of practice. In the actual rules found in Appendix A, it is easy to see that the standards for the APN/APRN appear to be less. Please remember, the APN/APRN must first be licensed as an RN in order to be eligible for a COA. Therefore the APN/APRN is held to all laws and rules that apply to the RN as well as those that apply to the APN/APRN.

Nursing Process

All nurses regardless of licensure level or educational level have heard of and been taught a process for systematically carrying out care. This systematic process is called the nursing process. The OBN, through rules in Chapter 4723-4 OAC, has set out the differences between the LPN and RN in carrying out the nursing process based upon the respective scopes of practice. Again, please recall that the APN/APRN is also an RN. Basically the nursing process for each is:

Registered Nurse

(1) Assessment:
  (a) Collect data. This includes:
    (i) Collection of subjective and objective data from the client, family, significant others, or other members of the heath care team. The registered nurse may direct or delegate the performance of data collection; and
    (ii) Documentation of the collected data.
(2) Analysis and reporting:
  (a) Identify, organize, and interpret relevant data;
  (b) Establish, accept, or modify a nursing diagnosis to be used as a basis for nursing interventions; and
  (c) Report collected data as necessary to other members of the health care team;
(3) Planning:
  (a) Develop, maintain, or modify the nursing component of the plan of care, including establishing desired client outcomes and interventions; and
  (b) Communicate the nursing component of the plan of care and all modifications of the plan to members of the health care team;
(4) Implementation:
  (a) Executing the current valid order or regimen by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;
  (b) Providing direct nursing care which is commensurate with the education, knowledge, skills, and abilities of the registered nurse;
  (c) Assisting with care of the client;
  (d) Delegating nursing tasks, including medication administration, only in accordance with Chapter 4723-13, 4723-23, 4723-26, or 4723-27 of the Administrative Code;
(5) Evaluation:
  (a) Evaluate, document, and report the client's:
    (i) Response to nursing interventions; and
    (ii) Progress towards expected outcomes of the plan of care; and
  (b) Reassess the client's health status, revise the nursing diagnoses or the nursing component of the client's plan of care, and make changes in the nursing interventions as necessary.

(Excerpted from Rule 4723-4-07 OAC) (Ohio Board of Nursing, 2010)

Licensed Practical Nurse

(1) Assessment:
  (a) Collect and document objective and subjective data related to the client's health status; and
  (b) Report objective and subjective data to other members of the health care team;
(2) Planning:
  (a) Contribute to the development, maintenance, or modification of the nursing component of the care plan;
  (b) Communicate the nursing component of the care plan and all modifications of the plan to members of the health care team.
(3) Implementation:
  (a) Administering medications and treatments prescribed by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;
  (b) Providing direct basic nursing care at the direction of:
    (i) A registered nurse;
    (ii) A licensed physician, dentist, optometrist, chiropractor, or podiatrist; or
    (iii) A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist;
  (c) Assisting with care of the client at the direction of:
    (i) A registered nurse;
    (ii) A licensed physician, dentist, optometrist, chiropractor, or podiatrist; or
    (iii) A certified nurse-midwife, certified nurse practitioner, certified registered nurse anesthetist, or clinical nurse specialist;
  (d) Collaborating with other nurses and other members of the health care team; and
  (e) Delegating nursing tasks, including medication administration, only in accordance with Chapter 4723-13, 4723-23, 4723-26, or 4723-27 of the Administrative Code; and
(4) Evaluation:
  (a) Contribute to the evaluation of the client's response to nursing interventions;
  (b) Document the client's responses to nursing interventions;
  (c) Communicate the client's responses to nursing interventions to members of the health care team; and
  (d) Contribute to the revision of the nursing component of the client's plan of care on the basis of the evaluation.

(Excerpted from Rule 4723-4-08 OAC) (Ohio Board of Nursing, 2010)

As you can see, the primary differences between the LPN and the RN with respect to the nursing process are analysis and reporting such that **only the RN** may analyze assessment data and formulate a nursing diagnosis.

Keeping Current

There is a strong need for all nurses to keep current on practice trends and research. This means that nurses must read journals, complete continuing education programs related to nursing practice, and when appropriate, participate in nursing research. Nurses are responsible and accountable for:

- Maintaining current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice and
- Demonstrating competence and accountability in all areas of practice in which the nurse is engaged. (4723-4 OAC) (Ohio Board of Nursing, 2010)

Continuing education activities and in-service education are 2 methods frequently used by nurses to obtain current knowledge and demonstrate competence and accountability in their respective areas of practice. Continuing education activities that nurses seek should be related to their area of practice. Nurses also have a duty to attend in-service education offered by the employer when a new procedure or piece of equipment is to be incorporated into the nurse's practice.

Provision of Nursing Care in an Ever-Evolving World

Nurses are able to provide nursing care to individuals as technology and research evolve, provided the nurse has kept up with the evolving changes. These concepts apply to medications as well. In the 1970's we had only a fraction of the medications on the market that are now available only 40 years later. With evolving changes in health care has come an increase in lifespan, such that the patients who are now frequently being cared for in all health care settings are older and present with more complex health care issues. When involved in the provision of nursing care in any setting, all nurses are again held to similar legal standards of nursing practice (See Appendix A). Nurses are well aware that health care is constantly changing. As health care changes, so must the knowledge of the nurse. For this reason, the standards related to nursing practice include nursing care which is beyond basic nursing preparation, provided:

(1) The nurse obtains education which emanates from a recognized body of knowledge relative to the nursing care to be provided;
(2) The nurse demonstrates knowledge, skills, and abilities necessary to provide the nursing care;
(3) The nurse maintains documentation satisfactory to the board of meeting the requirements above;
(4) The nurse has a specific current order from an individual who is authorized to practice in Ohio and is acting within the course of the individual's scope of practice; and
(5) The nursing care does not involve a function or procedure which is prohibited by any other law or rule. (4723-4 OAC) (Ohio Board of Nursing, 2010)

Carrying Out Orders

Most nurses understand that bathing someone who is extremely short of breathe could have a negative outcome for the patient, unless the nurse takes steps to minimize the oxygen demands being placed on the patient through nursing measures such as bathing the patient in stages, keeping the patient warm, and making sure that the patient's oxygen supply is flowing freely. No physician order is needed for a nurse to make such nursing decisions. That is just good nursing care. The rules are all encompassing, in that the wording allows for nursing decision making, but also ensures that the nurse is responsible for carrying out physician orders in a timely manner. LPNs, RNs and APN/APRNs are held to carrying out the orders of other licensed health care practitioners. Those orders are to be carried out *timely*. Timely is a relative term meaning that the time in which an order is to be carried out by the nurse depends on a variety of other things such as the condition of the patient or the timing of the medication with specific bloodwork, i.e., peak and trough times for an antibiotic. The nurse is expected to carry out or implement all valid orders for clients appropriately and according to practice standards while keeping the patient safe.

Occasionally, the nurse may make a decision not to follow a specific order from a physician. The nurse is permitted to do so, but in the meantime must clarify the order if the nurse believes the specific order is:

(a) Inaccurate;
(b) Not properly authorized;
(c) Not current or valid;
(d) Harmful, or potentially harmful to a client; or
(e) Contraindicated by other documented information. (4723-4 OAC) (Ohio Board of Nursing, 2010)

Perhaps the patient has a drug allergy, the nurse is then duty bound to hold the drug in question, contact the prescriber, clarify that the patient has a drug allergy and to request if an alternate drug may be ordered. In this case, *timely* would mean that the nurse contacted the prescriber *before* administering a drug to which the patient is allergic and seeking an alternate drug so the patient's needs are being met without interruption. When a nurse contacts a prescriber to clarify an order, the nurse is responsible to timely:

a) Consult with an appropriate licensed practitioner;
b) Notify the ordering practitioner when the nurse makes the decision not to follow the order or administer the medication or treatment as prescribed;
c) Document that the practitioner was notified of the decision not to follow the order or administer the medication or treatment, including the reason for not doing so; and
d) Take any other action needed to assure the safety of the client.

In the event that the nurse does not follow an order as prescribed, the nurse must, in an accurate and timely manner, report to the appropriate practitioner errors in or deviations from the current valid order (4723-4 OAC) (Ohio Board of Nursing, 2010).

Consult with Others

No one nurse can possibly know everything there is to know about nursing or healthcare. Luckily, we work in teams of nurses and health care professionals for the benefit of our patients. Nurses, like most people, each have different talents, levels of education and experience, and areas of expertise. Working as part of a team allows everyone's expertise to come through. The health care team may include other nurses, physicians, respiratory therapists, physical therapists, social workers, or any other of the many roles that make up the team of highly specialized professionals employed in health care today. The nurse is responsible for understanding his/her own limits and to report to and consult timely and as necessary with other nurses or other members of the health care team and make referrals as necessary (4723-4 OAC) (Ohio Board of Nursing, 2010).

Confidentiality

Nurses are held to a very high standard when it comes to keeping private, patient specific information in confidence. If a nurse is found to have violated such confidence, as with any other portion of the law or any rule, the nurse's license may be disciplined by the OBN. Confidentiality involves the sharing of patient information verbally, in writing, pictures, or even viewing the health care records of a patient for whom we are not caring for or involved in the care. Some health care systems have computerized medical records and each time a patient record is accessed the identity of the individual accessing the record is noted. This is one method used by employers to track that **ONLY** individuals involved in the care of a patient is accessing their records. A nurse should not use any personal digital communication device (i.e. cell phone or tablet) to take pictures of patients or even body parts of patients, such as a wound or bruise, even if the purpose is to show to another nurse or to send to the wound care nurse. Such photos are saved on the personal digital communication device and could be mistakenly viewed by individuals not directly involved in the care of that patient.

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Nurses are responsible to:

- Maintain the confidentiality of client information.
- Communicate client information with other members of the health care team for health care purposes only.
- To the maximum extent feasible, identifiable client health care information shall not be disclosed by a nurse unless the client has consented to the disclosure of identifiable client health care information.
- A nurse shall report individually identifiable client information without written consent in limited circumstances only and in accordance with an authorized law, rule, or other recognized legal authority (4723-4 OAC) (Ohio Board of Nursing, 2010).

Nurses are to use acceptable standards of safe nursing care as the basis for any observation, advice, instruction, teaching, or evaluation and communicate information which is consistent with acceptable standards of safe nursing care (4723-4 OAC) (Ohio Board of Nursing, 2010).

Promotion of Patient Safety

Patients are in a very vulnerable position in that they are entrusting nurses with private information and trusting that the nurse will use that information only to care for the health of the individual patient for whom the information is intended. The nurse is trusted by the patient, their loved ones, and other members of the health care team to provide safe and effective nursing care at all times. Patient safety is a large part of Standards of Practice Rule found in Chapter 4723-4 OAC.

Nurses must inform the patient, their family members, or other health care providers of the licensure level of the nurse. This may be done by displaying the applicable title of initials of the licensure level (LPN, RN, CRNA, CNM, CNP, or CNP) generally in the form of a badge on the front of the nurse's uniform. Or for patients who are blind, or with whom the nurse is speaking on the phone or using some other form of telecommunication, the nurse may verbally state the licensure level by saying simply, "My name is Nancy and I am the registered nurse caring for Mrs. Jones today." If the communication is written as in an email, fax or when documenting on a patient record the nurse must clearly write out the accepted initials that signify the respective licensure of the nurse, i.e. N. Smith, LPN. Please note; this is a requirement placed on the nurse by the OBN. The requirement is not placed on the employer.

The Board of Nursing also provides detail on how nursing care is to be delivered and documented. The nurse shall deliver care completely, accurately, and timely. Documentation of nursing care must include:

- Nursing assessments or observations;
- The care provided by the nurse for the client; and
- The client's response to that care.

Other patient safety measures that nurses, licensed to practice in Ohio, are required to use at all times include:

1. Promote a safe environment for each client.
2. Provide privacy during examination or treatment and in the care of personal or bodily needs.
3. Treat each client with courtesy, respect, and with full recognition of dignity and individuality. (Ohio Board of Nursing, 2010)

Professional Boundaries

Nurses provide personal care for people in a wide range of situations and settings. "Variables such as the care setting, community influences, patient needs and the nature of therapy affect the delineation of boundaries." (National Council of State Boards of Nursing, 2009). Delivery of nursing care outside of the traditional institution settings of hospitals and nursing homes, has been found to be an effective cost saving method of delivery. With the decentralization of health care delivery, nurses are able to exercise more autonomy. The patient is sometimes viewed as a friend or colleague, which has opened a host of issues related to professional boundaries.

As the professional in a nurse-patient relationship, the nurse is always responsible for establishing and maintaining professional boundaries with each patient and the patient is always presumed incapable of giving free, full, or informed consent to the behaviors by the nurse on a personal level. (Ohio Board of Nursing, 2010) (National Council of State Boards of Nursing, 2009). This is one area in which the Rules of the Board of Nursing are extremely explicit. Rule 4723-4-06 OAC states:

(K) A licensed nurse shall not:
  (1) Engage in behavior that causes or may cause physical, verbal, mental, or emotional abuse to a client;
  (2) Engage in behavior toward a client that may reasonably be interpreted as physical, verbal, mental, or emotional abuse.

(L) A licensed nurse shall not misappropriate a client's property or:
  (1) Engage in behavior to seek or obtain personal gain at the client's expense;
  (2) Engage in behavior that may reasonably be interpreted as behavior to seek or obtain personal gain at the client's expense;
  (3) Engage in behavior that constitutes inappropriate involvement in the client's personal relationships or financial matters; or
  (4) Engage in behavior that may reasonably be interpreted as inappropriate involvement in the client's personal relationships or financial matters.

(M) A licensed nurse shall not:
  (1) Engage in sexual conduct with a client;
  (2) Engage in conduct in the course of practice that may reasonably be interpreted as sexual;
  (3) Engage in any verbal behavior that is seductive or sexually demeaning to a client; or
  (4) Engage in verbal behavior that may reasonably be interpreted as seductive, or sexually demeaning to a client.

Within the context of professional boundaries and patient privacy, the idea of social media bears mention. Societal boundaries have been blurred by the advent of social media sites on which people are compelled to reveal their innermost thoughts or feelings on everything from the weather, to their love lives and work experiences. Nurses, being human and an important part of society are no exception. What is different, is that if a nurse chooses to share specific information about their day at work, not only is the employer likely to take issue that may lead to discipline of the nurse, but patients and their families may be harmed by having unauthorized personally identifiable information placed on the internet.

For the remainder of this independent study, please refer to CE4Nurses.org and click on Ohio Nurse Independent Studies.