President’s Perspective

Hi, from ANA\California:
I hope everyone has had a good summer. A thought for the coming months: instead of waiting until New Year’s to make the traditional resolutions, nurses can be thinking now, about what to do to change and improve. In addition to personal life changes, it’s a good time to think about the nursing profession and one’s career and educational goals. There may be no better time to consider going back to school. In the 2011 Institute of Medicine Future of Nursing report, the four key messages are:
• Nurses should practice to the full extent of their education and training.
• Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
• Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.
• Effective workforce planning and policy making require better data collection and information infrastructure.

The second of the key messages includes the goal to promote additional education and increase the number of BSN graduates as well as those graduating with masters’ degrees and higher. Ongoing learning is critical. Nurses must be prepared to keep up with new technology, changes in health care, and with the resulting increased challenges in the workplace. In the document "The Future of Nursing: Leading Change, Advancing Health," by the Committee on the Robert Wood Johnson Foundation of Nursing: Leading Change, Advancing Health, by Elissa Brown, President, ANA\California, the full document is available.

Florence Nightingale said: “Nursing is a progressive art, in which to stand still is to go back. A woman who thinks to herself, “Now I am a full nurse, a skilled nurse, I have learnt all there is to be learnt”—take my word for it, she does not know what a nurse is, and never will know; she is gone back already. Progress can never end but with a nurse’s life.” Florence Nightingale (1859)

Nurses need to become and stay involved. There are so many chances to do more in nursing, in the community and in life. Through belonging to your professional associations, there are exciting opportunities. We invite you to keep your membership in ANA\California, as the professional nurses association in California to which all nurses can belong. The ANA\California structure is such that each of four Board Directors has a specific focus, i.e., either Practice, Education, Legislation or Membership; and each officer has designated responsibilities. Working together, the Board members help one another bring strength to the organization and to the profession of nursing. Nurses can ask to be involved either on a committee or at least to be on the mail group for each of the 4 areas. Some of these groups have only ANA\members, others include nonmember nurses; however those who vote must be ANA\members. Please let us know if you would like to be more involved in any of these areas. In addition, many nurses belong to their specialty organization(s) and often serve as liaisons between ANA\ and their specialty nursing group.

A most important and exciting opportunity is coming up soon. This is where nurses can have their voices heard, plus a wonderful occasion to network.

Please join us at the: ANA\CALIFORNIA GENERAL ASSEMBLY, OCTOBER 29TH, 2011 AT WEST COAST UNIVERSITY IN ONTARIO, CALIFORNIA. We are most honored to have the ANA PRESIDENT, KAREN DALEY, presenting at this event! Please come and meet President Daley. There will also be a continuing education program on Simulated Learning, and a tour of the incredible state of the art West Coast U. campus. Enjoy the program, the networking, the food, and the silent auction. Please see the flyer in this issue of the Nursing Voice to register.

A Future of Nursing Update: California is one of the first 5 states selected by Robert Woods Johnson to establish a Regional Action Coalition, now called the California Action Coalition. The Statewide CAC and local groups, continue working together to address nursing’s future in California. California’s nursing leaders already had some structures in place that have fit in nicely with a state plan. ANA\California is involved at various points, on committees and coalitions, and has strong representative leadership in the CACs, regionally and statewide. Please be looking on our website for additional opportunities to become active participants.

Other issues: ongoing issues continue with Health Care Reform; with bills related to nursing practice, and more.
For an accomplishment, elected to office, won an award, accomplishment—

Tell us about it! Send name, address, phone number, and views of ANA\California, its membership, the board of directors or its staff.

You can also view the trailer on YouTube!

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ANA\California is located at 1121 L Street, Suite 409 Sacramento, CA 95814, Office 916-447-0225 Fax 916-442-4394

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Peace. It does not mean to be in a place where there is no noise, trouble or hard work. It means to be in the midst of those things and still be calm in your heart.—unknown

Members of the ballot committee and other experts met at the ANA/C office to review and revise the policies and procedures of our elections process. Members sought to reflect contemporary demands and to lay the groundwork for the use of emerging technologies. The goal is to simplify the process and save dues money. Louise Timmer, Marilyn Shirk, and Bonnie Faherty reviewed bylaws, practices of similar organizations, and past history to craft methodologies that will streamline our elections process. The committee was assisted by Susan Bowman, chair of the ANA/C bylaws committee, Elissa Brown, President, and ANA/C Executive Director, Tricia Hunter, and staff Samantha Marcantonio and Tommy Thompson. In addition, a time line to trigger actions that ensure a smooth process was created.

Recommended bylaws changes were discussed and will be referred to the Board of Directors for consideration by the next General Assembly. These bylaws changes reflect a desire to enable the use of new technology such as electronic communications and software. The needs of those members who do not use communication technology are always kept in mind.

The consent to serve form was streamlined to make it easier to complete and to include pertinent information voters need to have for their voting decisions. The A packet was developed to go to members interested in becoming candidates for ANA/C positions. Instructions to complete the candidate forms have been edited for clarity and to conform to current practice.

When the drafts are polished and finalized, they will be sent to the Board of Directors for their consideration. When accepted, an orientation booklet will be created for all

Prepares for the Future

ANA/C Ballot Committee

Bonnie Faherty, Chair
ANA/C Ballot Committee

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ballot committee members to assure they are aware of all the policies, procedures, timelines, and bylaws provisions related to their responsibilities. It is recommended that the Chair of the previous Ballot Committee orient and mentor the new Chair of the next Ballot Committee to ensure continuity and a seamless handover of responsibilities.

This meeting was a very productive four hours. Participants had all read and researched relevant aspects and were ready to make decisions to ensure that our election process is secure, fair, and reflects our values. On behalf of myself and the members of the committee, I wish to publicly acknowledge the preparation, teamwork, and especially the dedication and commitment of our staff and bylaws colleague, Susan Bowman, in assisting us to be thorough, efficient and to achieve the goals set out for this meeting.
Disaster Management and Nursing

Dianne Moore PhD MPH CNM RN
Director of Education ANA/C

There are over 300,000,000 people in the USA and just over 3,000,000 RN’s. There is about one RN for every 100 people in our country. Did you also know that 95% of the American people live in places of moderate to high risk for major disasters? California is particularly prone to natural disasters with having 98% of the state at high risk in all but 2 counties, Inyo and Mariposa. This is supported by FEMA reports of the ten high risk disasters in California in the last few decades. So how do these two facts blend together? Recently, the two national nursing accrediting bodies (NLNAC/CCNE) have identified that disaster nursing should be required content in nursing education. Some schools like the University of Arkansas and West Coast University have taken this fact to heart and developed entire courses devoted to Disaster Management. If you are wondering why Arkansas developed a Disaster Management course, it is because they actually lie on a major geologic fault line, have tornadoes, and a variety of other natural weather conditions. Arkansas’ geologic fault line is different than the ones in California, but when it erupts, it has the potential of being a very major disaster, so they must be prepared. West Coast University is located primarily in southern California and that community was subject to many major disasters in the last few years: fire, flooding, mud slides, earthquakes, storms and drought. To address a disaster preparedness need, the university developed a three credit course in its BSN program. Northern California has its share of disaster preparedness needs with issues of snow, ice storms, volcanoes, and Tsunami’s.

As part of the university learning more about disaster management and sharing its nursing education experience with other like professionals, the Associate Provost for Nursing Education and Regulatory Affairs, Dr. Dianne Moore, participated in the 17th World Congress on Disaster and Emergency Medicine, held in Beijing China in June 2011. Why and what can nursing learn from this experience?

Two abstracts related to why nurses should be educated about disaster management training, and how West Coast University conducts this education were invented and accepted. Part of the purpose was to demonstrate that all nurses should be prepared to fill whatever role is necessary in a disaster situation. That may be as a direct provider, a leader of a Disaster Management team, or on the ground coordinator. It is not a common part of nursing education that all nurses must take in natural disasters and the care of citizens.

In many people’s minds, the U.S. is not thought of as being a disaster prone country but in fact we are basically in a few geographic areas of the United States are “high risk” areas for disaster management, based on FEMA data and reports. The FEMA statistics are based on past disasters and indicated that the communities affected did not have enough resources to restore order and health and had to reach out to the federal government for help.

Now consider that fully 91% of America’s population lives in a high risk area and in California, 98% of the area is considered high risk. Because California is the most geographically and economically in the world, natural disasters can have a larger impact than some other areas of the USA or world. There are several approaches to preparing nurses to be ready including become certified as Disaster Management experts! Disaster Management is a new area of certification and well worth investigating for all nurses and health care facilities so they are better prepared in a disaster emergency. In the WCU Disaster Management course that was presented in Beijing, information about preparing students using FEMA-created modules on disaster management, Sigma Theta Tau modules on strategic planning, becoming part of the Medical Evaluation teams, Red Cross training and simulation clinical experiences are all part of the information presented as part of the West Coast University program. Part of the clinical experience involves working closely with community disaster drills, and using the simulation center for learning disaster management triage, a very difficult learning experience for some.

The disaster management experience also provides students opportunities to develop their critical thinking, management and leadership skills. Some have even used their artistic talent by developing entertaining videos to educate students on disaster safety right on their own campus. Other class assignments included making their own emergency kit, explaining to community organizations how to put together an emergency kit, and how to develop a community emergency plan.

The conference itself was enlightening because there was a lot of talk about the disasters that have happened over the past few years throughout the world. Three of the most significant recent disasters were earthquakes, but because of the different cultural, political and environmental conditions, each disaster had its own unique issues and side effects. Regardless of the setting, all three earthquakes stressed the importance for coordination of community services. For a variety of reasons, in many countries there was or is no one to coordinate disaster preparedness services. Whether it’s local help or people coming in from outside the country to provide emergency services, it is critically important to have someone on the ground coordinating services so disaster management teams can actually provide needed resources. This same principle applies to our own community settings and in each place we work or reside.

Over and over, I heard that in disaster situations, there is a need for two to three nurses for every doctor. In fact, what most people needed was nursing care—much more support service, and services that didn’t rely on computers and technology. Haiti was a prime example of this—there was no electricity or sanitation, let alone a technology infrastructure in place, so emergency service providers were on their own. Communication and clinical triage skills are the most important components for helping in a disaster, no matter where the disaster was located: far away or at home.

The bottom line is that disaster management requires a unique set of skills. Simple goodwill, will not provide what communities need, and might even cause harm (like having a mismatch of emergency personnel skills and the community’s needs, with the result that the emergency help uses scarce resources without bringing significant benefit). Overall, the conference theme was a need for more disaster trained nurses, coordination of services, and certification in disaster management.

Like the Boy Scout and Girl Scout motto says “Be Prepared.” Do you have a community disaster plan? If not, it is time to put one in place.
October, November, December 2011

by Phillip Miller, Vice President of Communications, AMN Healthcare

The relationship between hospitals and physicians although at times adversarial, has generally been symbiotic throughout most of the era of modern medicine. Physicians bring their specialized knowledge and skills to hospitals, and hospitals provide physicians with the facilities, equipment and personnel necessary to practice their art.

This benign paradigm is complicated by the fact that physicians are a key source of revenue for hospitals. In addition to their expertise, physicians also bring patients. Although hospitals engage in direct-to-consumer marketing and negotiate with third-party payers for patient lives, it is still the physician, in many cases, who ultimately determines to which hospital patients are admitted.

Every other year, Merritt Hawkins & Associates, an AMN Healthcare company, conducts a survey of hospital CFOs to determine the average amount of inpatient and outpatient revenue physicians in various specialties generate annually for their affiliated hospitals. Our 2007 survey indicated that the average for all physicians is about $1.5 million per year, although the average for surgical specialists is considerably higher (see www.merrithawkings.com).

In recent years, it appeared that direct competition between physicians and hospitals for this revenue would become the norm, as physician-owned hospitals and surgery centers proliferated. Today, a growing number of physicians are seeking hospital employment, restoring to some extent the symbiotic nature of the physician-hospital relationship. However, there is a new wrinkle: Physicians are no longer the only type of clinical professional driving revenue for hospitals because of the new payment system.

Satisfaction Matters

Indirectly, nurses have long had a hand in generating revenue for hospitals because of the close connection between nurse recruiting and retention and physician recruiting and retention. Hospitals with a full complement of qualified, motivated nurses tend to attract and retain physicians. Hospitals that are understaffed with overstressed nurses tend to lose doctors and have a hard time attracting them.

The influence of nursing care on hospital revenue is likely to become more pronounced as Medicare tracks hospital patient satisfaction through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The HCAHPS survey will make it easier for patients to evaluate a given facility, based on the assessment of patients who have been treated there. Those hospitals with high patient satisfaction scores are likely to attract more patients and generate more revenue than those with low scores.

As patient satisfaction becomes more critical to the bottom line, so does the importance of nurses. Indeed, in a survey of more than 300 hospital chief nursing officers (CNO) conducted by AMN Healthcare, 60 percent said that patient satisfaction metrics will enhance the status of nurses at their facilities. Medicare’s 2008 Inpatient Prospective Payment System rules are another factor increasing nurse influence on hospital revenue. The new rules stipulate that Medicare will not pay hospitals for care provided as a result of various hospital-acquired conditions (i.e., never events).

Nurses: A Source of Revenue

Nurse staffing plays a role because nurses, who continually monitor hospital patients, may be critical to preventing never events. According to the Agency for Healthcare Research and Quality, total costs for a surgery with an adverse event were $66,879 compared to $18,284 for surgeries without one. Under the new payment system, having a full complement of well-trained nurses could save hospitals considerable amounts of money. Seventy percent of CNOs in the AMN Healthcare survey said nurses will be considered a more important source of revenue at their facilities because of the new payment system.

Physicians, of course, are primarily concerned that their patients have a positive outcome at the hospital. It is reasonable to assume they will direct their patients to those facilities with the highest patient satisfaction scores and the fewest never events. This again demonstrates the connection between physician staffing and nurse staffing, which for strategic reasons, hospitals should consider collectively rather than separately.

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Travel Nurse Staffing: Quality Staff Equals Quality Outcomes

by Marcia R. Faller, RN, MSN
Chief Clinical Officer & Executive Vice President, AMN Healthcare

Travel Nurses Can Help Achieve Quality Patient Outcomes

Travel nurses are an essential resource in many hospitals as a means of providing adequate staff levels for patients. Quality patient outcomes are influenced by the quantity of nurses in the staffing formula, as evidenced by patient satisfaction survey results (Clark, Leddy, Drain, & Kolodner, 2004). In fact, evidence from the past two decades travel nurses have become a familiar solution to assuring that the quality of care is adequate.

Published reports have noted that some nurse leaders have balked at the use of travel nurses to supplement their staff due to a perception that the quality of temporary nurses have become a familiar solution to assuring that the bottom line. The most direct example of the quality–System rules, which state that hospitals will no longer be reimbursed for any hospital-acquired condition, such as certain mistakes that were noted, but were turned, considering personnel expenses and the impact on productivity and quality (Jones, 2004). Healthcare Research (HRH) also found that hospitals that perform poorly in nurse retention spend an average of $3.6 million more per year than those with high retention rates (PricewaterhouseCoopers HRI, 2007). Other studies have shown that turnover rates are lower for permanent staff nurses (Aiken, et al., 2007), which can lower turnover rates.

Challenge 7 — Changes in patient population (planned or unplanned)

Supporting Evidence—When hospitals experience fluctuations in patient census or undergo an addition or unit expansion or computer conversion, temporary nurse staffing can be a cost-effective solution to augment staffing levels for the duration of the project. In fact, all adverse events studied (pneumonia, pressure ulcers, infections, patient falls/ injuries, sepsis and adverse drug events) were associated with less time spent with patients and more chance of adverse outcomes. As the primary caregivers, nurses can help prevent infections, pressure ulcers, falls and other errors that impact patient outcomes, cost hospitals money and potentially result in lawsuits.

Supporting Evidence—A study published in American Journal of Nursing (2007) examined the impact of staff nurse shortages on patient outcomes in four hospitals. The study found that for every patient over four that a nurse takes in a patient care assignment, the mortality rate increases by 7% (Aiken, et al., 2002).

Challenge 2 — Restricted bed capacity and long waiting times related to ineffective patient flow

Supporting Evidence—Nurses spend the most time with patients, and patient satisfaction levels tend to revolve around how safe and well cared for they feel. If nurses are understaffed and nursing care is rated as high during their hospital stay, chances are that their overall satisfaction will also be high, and they will be more likely to recommend the facility to the future. Patients also have a strong influence on the healthcare choices of their family and friends.

Challenge 4 — Public disclosure of patient satisfaction metrics

Supporting Evidence—The Centers for Medicare and Medicaid Services (CMS) have announced that hospitals will be required to publicly report the results of patient satisfaction surveys (the Hospital Consumer Assessment of Healthcare Providers and Systems Survey, or HCAHPS), which will likely influence potential patients in their selection of a hospital provider. This information was added to the Dept. of Health & Human Services’ “Hospital Compare” online tool starting in March 2008 (PricewaterhouseCoopers HRI, 2007) and is currently available to the public. The hospital compare website also offers comparison of numerous disease-state quality metrics.

Travel Nurses and ANCC Magnet® Designation Program®

There is a resurgence of interest in Magnet qualities in hospital circles. Some nurse leaders believe that Magnet designation is no longer enough. The push for Magnet designation by the American Nurses Credentialing Center (ANCC)—do not or cannot use travel nurses and still achieve/retain their Magnet designation. This is not accurate. There is nothing in the 14 Forces of Magnetism that restricts the use of supplemental nurses. In fact, travel nurses may even help hospitals achieve Magnet designation. A recent survey of chief nursing officers (CNOs) highlighted two specific areas where travel nurses can contribute to the Magnet journey: stabilizing and improving retention of quality patient care and outcomes (Windsor, 2007). In addition, travel nurses allow permanent staff to participate in Magnet-required training, share experiences from other Magnet facilities, and add to the Magnet journey through networking opportunities (Windsor & Case DiLeonardi, 2007). At the 11th ANCC Magnet Conference in Atlanta, Georgia, in October 2007, AMN supported a presentation by three nurse leaders discussing how travel nurse utilization helped them in their journey to Magnet designation. The group repeated this presentation, entitled “Partnering with Travel Nurses on the Magnet Journey,” as a Web cast in December 2007. Both the Web cast and white paper were available on AMN’s Web site at www.amnhealthcare.com.

Travel nurse staffing makes up a significant part of the larger healthcare staffing industry (which includes temporary, per diem, and agency staff) (Staffing Industry Analysts, 2007), up from $5.3 billion in 1998. As the industry has grown, so have the needs and expectations from the healthcare facilities that use these staffing services. Nurse leaders should expect their contracted staffing agencies to support a hospital’s efforts in providing quality care to the patient care, which may include overstaffing during the rest of the year, understaffing for the duration of the project. It helps avoid the costs of overstaffing during the rest of the year, under-staffing during peak periods (which can lead to diverted patients and increased errors) and excessive overtime (Windsor, 2007), which can overburden staff and lower the quality of patient care.

Travel Nurse Staffing continued on page 7

What to Expect from Your Staffing Agency

Over the course of the last 30 years, travel nurse staffing has evolved into an industry of its own standing. No longer solely dependent on seasonal fluctuations in the supply of nurses, travel nurse staffing agencies have turned to the opening of new units or technology implementations, to fill vacancies due to the Family Medical Leave Act (FMLA) or other leaves of absence and to provide adequate staffing when vacancies are chronic.

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As with its hospital accreditation program, Joint Commission on Accreditation of Healthcare Organizations is continuously raising the bar for healthcare staffing companies. Each year the standards are more refined and in 2008 performance measures were required. Performance measures in three areas were pilot tested by the Joint Commission during 2006. AMN was one company among several that provided data to test the measures, and in all three areas AMN returned better performance than the benchmark.

Overall, The Joint Commission’s certification program has been positive for the industry, and many facilities now require that their staffing partners are Joint Commission certified.

Organization’s Purpose, Mission and Values. One way to determine whether a staffing organization is committed to quality is to review its formal statements, and determine how well they spell out the corporate mission, purpose and values. AMN’s purpose is “Helping achieve professional and personal goals of our clients, our employees, our healthcare systems, and our communities for patient care quality and revenue.” This purpose statement encompasses our commitments to healthcare professionals, hospital customers and corporate team members. For travel nurses, we work to provide them with the best career opportunities at hospitals across the country. For hospital customers, we provide the highest quality staff nurses to help accomplish their goals for patient care quality and revenue. As a component of its mission, AMN’s management and philosophy is a broad statement that encompasses our commitments to healthcare professionals, hospital customers and corporate team members. For travel nurses, AMN provides employment at a quality work site, with opportunities for growth and development.

AMN’s values statement reinforces a commitment to quality to our customers through quality efforts and continuous improvement. Our defined corporate values are: respect, trust, passion, customer focus, and continuous improvement.

Quality Management is the credentialing department. Staff members within this department are responsible for assisting travel nurses with the preparation of credentials prior to their assignment at a host site, such as authenticity, online and fully accessible to those within the department. Ongoing clinical assessments are documented for future use in performance evaluation.

Quality Management is the credentialing department. Staff members within this department are responsible for assisting travel nurses with the preparation of credentials prior to their assignment at a host site. Staff members within the department review all documentation for applicability, background checks and drug testing, license renewal, and social security number. AMN’s credentialing program utilizes a computer system with current knowledge of the hospital, state and federal requirements with a travel nurses’ quality management

As a result of AMN Healthcare’s quality program, Joint Commission on Accreditation of Healthcare Organizations has been positive for the industry, and many facilities now require that their staffing partners are Joint Commission certified.

Establishing a comprehensive quality program is necessary for travel nurse staffing companies, and should be a qualifying factor for facilities when choosing an agency. AMN has maintained it position as the industry leader for nearly 26 years. Surveys of customer hospitals have confirmed that our focus on high standards results in perceptions of a level of quality that is not seen in other companies. Supporting a strong quality program is a crucial aspect of a travel nurse staffing business for several reasons:

1. Quality of staff placed on assignments is a reflection of the company’s commitment to quality to the client facilities, as well as to their patients.

2. A strong quality program will reap benefits for the organization in terms of repeat business and increased usage by client facilities.
5 Reasons Nurses Want to Leave Your Hospital

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October, November, December 2011

5 Reasons Nurses Want to Leave Your Hospital

Rebecca Hendren, for HealthLeaders Media, August 9, 2011

Your nurses have one eye on the door if you do any of the following:
- Although economic woes abound, nurses are planning their exit strategies and will make a move when things improve. A recent survey from healthcare recruiters AMN Healthcare found that one-quarter of the 1,002 registered nurses surveyed say they will look for a new place to work as the economy recovers.
- Are your nurses engaged, committed employees? Or are they biding their time until they can go somewhere better?
- To predict whether you face an exodus, take a look at the following five reasons why your nurses want out.

1. Mandatory overtime
Nurses work 12-hour shifts that always end up longer than 12 hours due to paperwork and proper handoffs. At the end, they are physically, mentally, and emotionally exhausted. Forcing them to stay longer is as bad for morale as it is for patient safety.

Some overtime is acceptable. People get sick, take vacations, or have unexpected car trouble and holes in the shift must be filled to ensure safe staffing. Nurses are used to picking up the slack, taking overtime, and pitching in. In fact, overtime is an expected and appreciated part of being a nurse. Many use it to help make ends meet. Mandatory overtime, however, is a different matter. Routinely understaffed units that rely on mandatory overtime as the only way to provide safe patient care destroy motivation and morale.

Take a look at the last couple of years’ news stories about RN picket lines. Most include complaints about mandatory overtime.

2. Floating nurses to other units
One nurse is not the same as another. Plugging a hole in a geriatric med-surg unit by bringing in a nurse from the pediatric floor results in an experienced, competent nurse suddenly becoming an unskilled newbie. A quick orientation won’t solve those problems. Forced floating is usually indicative of larger staffing problems, but even so, its routine use is dissatisfying and compromises patient safety.

Instead, create a dedicated float pool staffed by nurses who volunteer and who can be prepared and cross-trained. Institute float pool guidelines that nurses float to like units. For example, critical care nurses find a step-down unit an easier transition than pediatrics.

3. Non-nursing tasks
Nurses are already understaffed and overworked. Hospitals with too few assistants rub salt on the wounds. RNs shouldn’t have to take time from critical patient care activities to clean a room or collect supplies. Gary Sculli, RN, MSN, ATP, patient safety expert and crew resource management author, offers a vivid analogy. Imagine if half way through a flight you saw the pilot come down the aisle handing out drinks because the plane was short staffed. It just wouldn’t happen.

Yes, cleaning a room is important, but don’t force nurses’ attention away from their patients. Distractions are dangerous and compromise patient safety.

4. Bullying and toxic behavior
Bored of hearing about this topic? So am I. So are nurses. Nothing makes nurses want to walk out the door more than toxic colleagues—whether physicians, nurses, or anyone else—who are allowed to behave badly.

It’s not enough to have a zero-tolerance policy. Enforce it. Preach it. Talk about the importance of respectful behavior. Explain expectations, not just at orientation but at multiple times through the year. Send information via emails, hold continuing education classes, and have the topic as a standing item on meeting agendas.

Give managers the tools to confront problem employees and back them up when they do. Have a plan in place to educate offenders. If the behavior continues after that, fire them. Support managers through this work. Nurses would rather work a nurse short than keep a disruptive employee who sabotages the morale and cohesiveness of the others.

5. Bad managers
You’ve heard it before: People don’t leave companies, they leave managers. Yet hospitals still don’t pay enough attention to leadership skills for nurse managers. Bad nurse managers who don’t know how to lead are retention nightmares. Skilled managers are retention magnets.

Some hospitals have good managers who are stretched so thin they become bad ones. How can anyone focus on the professional development of their staff if they’re overseeing several units with untrained nurses across all shifts? Annual performance reviews shouldn’t be the only time the manager and nurse engage in conversation. Nurse managers must help staff reflect on growth and plan for the future.

These five reasons affect every aspect of nursing workload and contribute to fatigue and burnout. Don’t forget that nurses always know when their colleagues at the hospital across town are happier.

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involved with the ANA collaboration of associations who are working for a common scope of practice specifically as it relates to consumer access. She is a citizen advocating for the needs of consumers. Citizen Advocacy Center is working to get the public moving toward competency based reviews for licensure and certification. 

There is a movement in the state to punish licensees and eliminate diversion programs. The Medical Board lost their diversion program because of a belief that the program was mishandled. The BRN Diversion program has kept statistics and data that demonstrates a very successful program. Through the legislative hearing process, laws were recommended and passed that tighten the system. We are all open to improvement but believe that the program is good for nursing and patients. Having a process for nurses to self-report and be removed from the work site is in every patient’s best interest. 

The NCSN program presented data from programs across the United States. They shared best practices and research based success. A publication on Diversion and Probation, outlining the best practices and recommended standards was developed out of the data. This publication is available for all public policy advocates and for the Board of Registered Nurses. 

The Program on the Compact states shared data on common myths and problems that have impacted the compact states. There are 18 states that are part of the compact. Most of these are rural states and none of them have close to the number of licensees the state of California has. One of the most common problems is the nurse defining her “home state.” This is the state the nurse has identified as her primary address. The nurse can have a different mailing address. The significant of this is the home state is the primary license. Only the home state can discipline the nurse, the compact states or “remote state” can remove the privilege to participate in the compact but they cannot remove the license. There has to be the trust in the system that the home state will take action against the licensee if the compact state finds grounds for discipline.

Nick Sabatini, the retired Administrator for Aviation Safety, presented a program on July 31. He described a system that allows sharing of data to prevent accidents. He recognized the aviation industry is fortunate that there is only one government entity involved. He described building a relationship with industry and labor that allowed a sharing of information that has helped identify potential risks in the industry and develop tools to prevent accidents. The agency has protection from public disclosure so the data can be shared with the industry, protected from lawsuits. Much of what he described is where we need to go with healthcare. A system that allows mistakes or near mistakes to be shared nationally so we could all learn from it would go far in addressing medical mistakes. The system would need the authority to change the systems they identified problems with quickly.

Mark Yessian, from Citizen Advocacy Center, discussed the need for the Boards to be consumer responsive. He suggested that consumer complaints should be handled differently from other complaints by the Boards. He suggested, even when the board did not have jurisdiction, the board should have a communication system to get back to the consumer individually. He also talked about how we gave messages and that we make sure the consumer protection concept be key in what we write and share with the public. 

Rebecca LeBohn, Citizen Advocacy Center, discussed how Scope of Practice laws affect the needs of Consumers. Citizen Advocacy Center is working to get the public involved with scope of practice specifically as it related to consumer access. She is involved with the ANA collaboration of associations who are working for a common interest in Washington, DC. There organization is monitoring how professions are moving toward competency based reviews for licensure and certification.
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The annual meeting of the National Council of State Boards of Nursing (NCSBN) was an informative but noncontroversial meeting this August. Under the leadership of Kathy Apple, MS, RN, FAAN, Executive Director, the NCSBN has reached out to communicate with the interested advocates and though they do not always agree, the controversy is a lot less. The collaboration with external organizations by the NCSBN Board and council staff included 32 nursing groups, nursing associations or state Boards of Nursing. The NCSBN is involved in three major research studies and updates on both were shared in this article.

TERCAP (taxonomy of Error, Root Cause Analysis and Practice Responsibility) is a database designed to collect the practice breakdown data from state boards of nursing to identify the root causes of nursing practice breakdown. In 1999, a task force was created to look at nursing discipline issues and results in a tool being developed in 2007 to collect the data about discipline practice issues. There are 22 state nursing boards participating in the study. The data consisted of situations in which a nurse had a practice breakdown that involved one or more patients resulting in disciplinary action.

The breakdown of the 861 nurses who committed practice breakdowns in the study to date is as follows: 83% were female, 17% were male; the average age of the nurse was 46.2 ranging from 21 to 77, 60% were RNs, 37% were LVN/LPN and 3% were LPNs. Of those disciplined, 92% had their license in hospitals, 32% long term care, 17 outpatient, 3% behavioral health and 10% were “other.” Of the nurses disciplined 20% had their license less than 5 years, 17% had their license 5 to 10 years, 22% had their license 11 – 20 years, 18% had their license 21 to 30 years and 8% had their license longer than 30 years.

The work history of the nurses disciplined indicated that 55% of them had worked in the location for two years or less but 73% of them had been licensed for two years or longer. The disciplined nurse data indicated that 40% had never been disciplined in their practice while 16% had been disciplined and 22% had been terminated with another 22% of nurses had both. This indicates that 36% of the nurses disciplined by the Board of Registered Nursing (BRN) had issues in the workplace that resulted in an incident that affected a patient. Of these nurses, 36% had been previously disciplined but not more significant, 38% had been terminated in a previous position. There was a significant link between the employment history of the nurse and practice breakdown. The California BRN has debated the issue for years as to whether a law should be passed requiring the termination of a nurse in the workplace be reported to the licensing boards. An LVN who is terminated is report to the BVNPT Board. There is no such law for a registered nurse who is terminated. The practice breakdown was 89% in more than one category and 11% in one category, 72% involved no intentional error; 52% did not cause patient harm; 59% resulted in disciplinary actions, and 23% were sanctioned non-disciplinary actions.

Lack of Professional Responsibility 7%
Lack of Clinical Reasoning 5%
Lack of Intervention 50%
Documentation Error 32%
Medication Error 40%
Lack of Interpretation 20%
Lack of acknowledgement 24%
Lack of Prevention 20%

Simulation Study
Ten schools are involved with a simulation study for student nurses, measuring the amount of clinical done by simulation versus clinical in a hospital setting and determining the effects that the new graduate nurse has in the workplace. The control group has simulation study at 10% or less. One of the study groups will receive 25% simulation and a third group will receive 50% of their clinical through simulation. The schools were selected last year and the study has just begun. This study could impact the amount of simulation clinical the nursing schools are allowed to substitute for hospital clinical.

A transition to Practice Pilot is also going to be implemented with 25 institutions in each state identified.
Possible Consequences
Potential consequences for inappropriate use of social and electronic media may range from reprimand to sanctions based on the basis of disciplinary action by a BON vary between jurisdictions. Depending on the laws of a jurisdiction, a BON may investigate reports of inappropriate disclosures on social media or in electronic media.

- Unprofessional conduct;
- Unethical conduct;
- Moral turpitude;
- Mismangement of patient records;
- Revealing a privileged communication; and
- Breach of confidentiality

BON Implications
Instances of inappropriate use of social and electronic media may result in reprimand or sanctions. A mistaken belief that the content once posted or sent is no longer accessible or can be deleted is a breach of confidentiality. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.

The ease of posting and commonplace nature of sharing information via social media may allow to blur the line between one's personal and professional lives. The quick, easy and efficient technology enabling use of social media reduces the amount of time it takes to post content and simultaneously, the time to consider whether the post is appropriate and the ramifications of inappropriate content.

How to Avoid Problems
It is important to recognize that instances of inappropriate use of social media can and do occur, but nurses are typically protected from liability in disclosing confidential or private information about patients.

The following guidelines are intended to minimize the risks of using social media:

- First and foremost, nurses must recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality.
- Nurses are strictly prohibited from transmitting by way of any electronic media any patient-related information that is protected from transmitting any information that may be reasonably anticipated to violate patient rights to confidentiality or privacy, or otherwise degrade or undermine the trustworthiness of the profession.
- Do not share, post or otherwise disseminate any information, including images, about a patient or information gained in the nurse-patient relationship with anyone unless there is a patient related need to disclose the information or other legal obligation to do so.
- Do not identify patients by name or post any information that may lead to the identification of a patient. Limiting access to postings through privacy settings of social media can sometimes help to protect patient privacy.
- Do not refer to patients in a disparaging manner, even if the patient is not identified.
- Do not post images or comments of patients on personal devices, including cell phones. Follow employer policies for taking photographs or videos of patients for treatment or other legitimate purposes using employer-owned equipment.
- Maintain professional boundaries in the use of electronic media. Like in-person relationships, the nurse has the obligation to establish, communicate and enforce professional boundaries with patients in the online environment. Use caution when having online social contact with patients or former patients.
- Consider employer policies and/or an appropriate leader within the organization for guidance regarding work related postings.
- Promptly report any identified breach of confidentiality.

Be aware of and comply with employer policies regarding use of employer-owned computers, cameras and other electronic devices and use of personal devices in the workplace.

A mistaken belief that content that has been deleted may still exist, or that content that has been saved for future use will be forgotten is also a breach of confidentiality.

A mistaken belief that it is harmless if private information about patients is disclosed if the communication is accessed only by the intended recipient is also a breach of confidentiality.

A mistaken belief that it is acceptable to discuss or refer to patients in a way that are not identified by name, but that are identifiable by circumstances such as date of birth or diagnosis condition. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.

A mistaken belief that the content once posted or sent is no longer accessible or can be deleted is a breach of confidentiality. This too is a breach of confidentiality and demonstrates disrespect for patient privacy.

A mistaken belief that content once posted or sent is no longer accessible or can be deleted is a breach of confidentiality.
Bob, a licensed practical/vocational (LPN/VN) nurse with 20 years of experience used his personal cell phone to connect with former coworkers while he worked. Prior to taking the photo, Bob asked the resident's brother if it was okay for him to take the photo. The brother agreed. The resident was unable to give consent due to his mental condition. That evening, Bob, a former employee of the group home at a local bar and showed the picture. Bob also discussed the resident's condition that morning during a staff meeting. The group home learned of Bob's actions and terminated his employment. The matter was also reported to the BON. Bob claimed that he thought it was acceptable for him to take the resident's photo because he had the consent of a family member. It was acceptable for him to discuss the resident's condition because the care plans were not located within the company and had worked with the resident. The nurse acknowledged he had no legitimate purpose for taking the photo. He was restricted from discussing any patient's condition. The BON imposed disciplinary action on Bob's license requiring him to complete continuing education on patient privacy and confidentiality, ethics and professional boundaries.

This case demonstrates the need to obtain valid consent before taking photographs of patients; the impunity of using a personal cell phone to take a patient's photo; and that confidential information should not be disclosed to persons no longer involved in the care of a patient.

**SCENARIO 2**

Sally, a nurse employed at a large long-term care facility arrived at work one morning and found a strange email on her computer screen. It was from an employee of the facility that it was sent during the previous nightshift. Attached to the email was a photo of what appeared to be an elderly female who had been described as being in a wheelchair and was under a table that was felt to be the During the nightshift. Attached to the email was a photo of what appeared to be an elderly female who had been described as being in a wheelchair and was under a table. The email was from an employee of the facility that it was sent during the previous nightshift. Attached to the email was a photo of what appeared to be an elderly female who had been described as being in a wheelchair and was under a table. The email was from an employee of the facility that it was sent during the previous nightshift. 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SCENARIO 7

Jamie has been a nurse for 12 years, working in hospice for the last six years. One of Jamie’s current patients, Maria, maintained a hospital-sponsored communication page to keep friends and family updated on her battle with cancer. Jamie periodically read Maria’s postings, but had never left any online comments. One day, Maria posted about her depression and difficulty finding an effective combination of medications to relieve her pain without unbearable side effects. Jamie knew Maria had been struggling and wanted to provide support, so she wrote a comment in response to the post, stating, “I know the last week has been difficult. Hopefully the new happy pill will help, along with the increased dose of morphine. I will see you on Wednesday.” The site automatically listed the user’s name with each comment. The next day, Jamie was shopping at the local grocery store when a friend stopped her and said, “I didn’t know you were taking care of Maria. I saw your message to her on the communication page. I can tell you really care about her and I am glad she has you. She’s an old family friend, you know. We’ve been praying for her but it doesn’t look like it’s going to happen. How long do you think she has left?” Jamie was instantly horrified to realize her expression of concern on the webpage had been an inappropriate disclosure. She thanked her friend for being concerned, but said she couldn’t discuss Maria’s condition. She immediately went home and attempted to remove her comments, but that wasn’t possible. Further, others could have copied and pasted the comments elsewhere.

At her next visit with Maria, Jamie explained what had happened and apologized for her actions. Maria accepted the apology, but asked Jamie not to post any further comments. Jamie self-reported to the BON and is awaiting the BON’s decision.

This scenario emphasizes the importance for nurses to carefully consider the implications of posting any information about patients on any type of website. While the website was hospital-sponsored, it was available to friends and family in some contexts it is appropriate for a nurse to communicate empathy and support for patients; but they should be cautious not to disclose private information, such as types of medications the patient is taking.

References


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