President’s Perspective

Elissa Brown
President, ANA\California

It is quite refreshing to attend meetings with other nurses, to network, to feel reinvigorated about nursing.

Two recent events provided us with renewed enthusiasm about our profession and our association. The ANA California General Assembly, on October 29th, 2011 at West Coast University in Ontario, California was a success. ANA President, Karen Daley, was our special guest and gave an inspiring keynote speech. The continuing education program on Simulated Learning, and a tour of the beautiful state of the art West Coast University labs, was very exciting. Overall, the program, the networking, the food, and the silent auction went very well. Thank you to President Daley for making the time in her busy schedule; and thank you to Diane Moore, and West Coast University for helping to make this a memorable event. And, thank you to the ANAIC Board and staff, and members who helped with planning this General Assembly.

The other recent happening was attended by a few of us in Silver Spring, Maryland at the ANA Constituent Assembly (CA). Tricia Hunter and I, as ANACalifornia (ANA\California) Executive Director and President, and Liz Dietz as an ANA Board member, recently attended the ANA Board meeting and the ANA CA. This was another productive and refreshing set of meetings. The atmosphere of sharing and mutual respect present during the long weekend meetings facilitated important work and was very much appreciated.

There was much discussion on current happenings throughout the states and other constituents, on health care reform, and on how do we reach out to other nurses and to nursing students. Some innovative ideas were shared, as well as lessons learned.

The concept of leadership was also discussed. Nurses can be leaders in any role, not just those traditionally viewed as administrative. There is leadership at the bedside, in education and in other settings. In appealing to that leadership “gene,” or potential, in all nurses, please consider getting more involved in the nursing profession, in professional associations and in the community.

There is much talent among our members. Let’s capitalize on that, and learn from each other. ANACalifornia wants to hear from our members about what you more would like to see in the way of programs, outreach, and opportunities for involvement.

Please keep your membership in ANAIC current, or join if you have not. ANAIC is the professional nurses association in California open for all RNs to belong.

A recap on our structure: The ANAC has four officers with distinct responsibilities and four Board Directors, each with a specific focus, i.e., either Practice, Education, Legislation or Membership.

Board members work hard as a group, helping each other, and bringing strength to the association and to nursing. Nurses can be involved either on committees with the Directors or at least as part of their mail groups. Some of these groups have only ANAIC members, others include nonmember nurses; however those who vote must be ANAIC members.

Please do contact us at ANAIC, about what you would like to do to be more involved in ANAIC activities. Think about your own strengths, interests and what more you would like.

Nurses may also choose to belong to their specialty organization(s) and often serve as liaisons between groups, which brings rewards for everyone.

Another Future of Nursing Update: Members of ANAIC and other nurses are involved with the California Action Coalition—the Statewide CAC and local groups continue working together to address nursing’s future in California. As mentioned before in the Nursing Voice, ANACalifornia is quite involved on committees and coalitions, and has strong representative leadership in the CACs, regionally and statewide. Recently I was appointed as the regional Co-Leader for the Los Angeles area, along with Dr. Rosie Curtis who has been in the role for awhile. Please check our website for updated information, links and opportunities to become active participants.


Ongoing issues: many healthcare reform issues continue being discussed; including the future of nursing initiatives. As the recently re-elected Vice-Chair of the Executive Committee of the ANA Constituent Assembly (CA: is the group of the Presidents and Executive Directors of all of the states plus a number of other constituent groups), I shall continue to bring information to the state. There are regular calls with the ANA President, and with regional groups.

ANAIC will keep you updated. And, please visit the American Nurses Association website, as well: www.nursingworld.org for the latest national information about health care issues, healthcare reform and professional nursing issues on a national level.

Registered Nurses are a trusted “caring” power in healthcare. Please do take opportunities to get more involved through work, professional associations and the community—at local, state, national and international levels.

My continuing gratitude to current and future members, to our hard working ANACalifornia Board members and staff who work to provide in their own work settings, and give their volunteer time to promote quality healthcare for the public, participate in future of nursing programs, support the nursing profession, ANACalifornia and ANA.

And thank you to all nurses for what you do.

Comments, questions and suggestions are welcome.

“My must do the things you think you cannot do.”- Eleanor Roosevelt
ANA California accepts and encourages manuscripts and editorials be submitted for publication in the association's quarterly newsletter, The Nursing Voice. We will determine which letters and articles are printed by the availability of publication space and appropriateness of the material. When space is available, ANA California members will be given first consideration for publication. We welcome signed letters of 300 words or less, typed and double spaced and articles of 1,500 words or less. Articles printed in The Nursing Voice do not necessarily reflect the views of ANA California, its membership, the board of directors or its staff.

ANA California's official publication, 'The Nursing Voice' editorial guidelines and due dates for article submission is as follows.

1. Manuscripts should be word processed and double-spaced on one side of 8 1/2’ x 11 inch white paper. Manuscripts should be emailed to Editor at Thenursingvoice@yahoo.com
   a. Manuscripts should include a cover page with the author’s name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.
   b. The Nursing Voice reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.
   c. The Nursing Voice reserves the right to edit manuscripts to meet style and space limitations.
   d. Manuscripts may be reviewed by the Editorial Staff.
   e. Articles submitted by members of ANA California will be given first consideration when there is an availability of space in the newsletter.

2. Photographs should be of clear quality. Write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to: Samantha Hunter, Editor, The Nursing Voice c/o ANA California, 1121 L Street, Suite 409, Sacramento CA 95814. Or email photographs in jpeg format to thenursingvoice@yahoo.com

3. E-mail all narrative to Thenursingvoice@yahoo.com

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I’m a nurse, an educator, a mother, and grandmother. I am also the President of the Marin County Board of Supervisors. I’ve been a nurse for 33 years and have worked as a women’s health nurse practitioner building healthy families. As a County Supervisor for the past 9 years, I’ve worked to create healthy communities.

Congress has plenty of lawyers, but only 7 of its 435 members are nurses—including just one nurse from California’s delegation, Congresswoman Lois Capps. Less than 1% of our congressional leaders are women. With the serious challenges facing our country, I will bring a woman’s voice and a nurse’s voice to Congress as we build “healthy families and healthy communities.” I am honored to have the endorsement of the American Nurses Association.

As nurses, we understand what our health care system needs because we work in it. We care for ill patients in their homes and clinical settings. We educate our patients, community, policy makers, and future health care providers. We’ve worked double shifts. We’ve seen firsthand the danger to nurse and patient alike when there aren’t safe staffing levels. We are on the front lines fighting for the rights of nurses, patients, and the future of our health care system. Working as a nurse in a number of venues—both at the patient bedside, in the classroom, and in outpatient settings. I received my undergraduate degree from San Francisco State. As a women’s health nurse practitioner, I had a clinical practice at UCSF—and represented nurses during the UCSF-Stanford merger, negotiating the first closed shop. My doctoral work at UCSF focused on drug addiction and pregnancy. I have been on faculty at Dominican University where I most recently taught a graduate course in health care policy. I have been an advocate for a single payer health care system for over 25 years.

My experience in the healthcare field is what shapes my perspective as an elected official. Whether it’s creating the Marin Clean Energy authority to move our County off the fossil fuel grid; creating innovative “therapeutic justice” programs that reduced recidivism in our jails by 85% and psychosis emergency visits by 55%; or establishing the Marin Health & Wellness Campus which was built with tobacco settlement money; everything I do centers around creating healthy families and healthy communities and ultimately a healthy planet.

I am running for Congress to make California’s communities healthier, greener, and more sustainable. I will focus on creating jobs, implementing health care reform, and protecting the safety net for our most vulnerable.

With an estimated 33 million new patients entering the health care system as a result of the Affordable Care Act, we need to ensure there is access to health care. Having health insurance doesn’t necessarily translate to health care access. Expanding nurse-run clinics could be one option.

We must also expand educational opportunities for nurses, like offering student loan forgiveness for nurses who provide clinical services in rural and underserved communities. Between the aging population and the veterans returning from war, we are going to need more nurses, and more health care providers in the coming years, including veterans returning from war, we are going to need more nurses, and more health care providers in the coming years, including more nurses and more health care providers in the coming years, including nurses and more health care providers in the coming years.

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As nurses, many of us know what it’s like to pick up our plan…and who better to heal the House than a nurse? Across the country, nurses are leading the way to heal our broken health care system. As a County Supervisor for the past 9 years, I’ve worked to create healthy communities. As a women’s health nurse practitioner building healthy families. As a County Supervisor for the past 9 years, I’ve worked to create healthy communities.
California has an annual legislature. Every year there is discussion about an initiative to change us from a full time legislature to a part time legislature. This is a very important issue for health care. The following is a discussion of the pros and cons.

Legislatures continually look for ways to improve their effectiveness. One reform that often is debated is annual versus biennial legislative sessions. In the early 1960s, only 19 state legislatures met annually in regular session. The remaining 31 held biennial regular sessions. Most held their biennial session in the odd-numbered year; only Kentucky, Mississippi and Virginia met during the even-numbered year. By the mid-1970s, the number of states meeting annually grew tremendously—up from 19 to 41. Today, 46 state legislatures meet annually. The remaining four states—Montana, Nevada, North Dakota, and Texas—hold session every other year, and all of these biennial legislatures hold their regular sessions in the odd-numbered year.

Oregon, Arkansas, Kentucky, New Hampshire and Washington were the last states to change from biennial to annual regular sessions; these states held their first annual sessions in 2011, 2009, 2001, 1985 and 1981, respectively.

There are several basic arguments used by the respective proponents. Listed below are the ones set out by political scientists, William Keefe and Morris Ogul.

1. The biennial format is unsuitable for dealing with the complex and continuing problems which confront today’s legislatures. The responsibilities of a legislature have become so burdensome that they can no longer be discharged on an alternate-year basis.

2. More frequent meetings may serve to raise the status of the legislature, thereby helping to check the flow of power to the executive branch.

3. Continuing legislative oversight of the administration becomes more feasible with annual sessions, and that administrative accountability for the execution of legislative policies is more easily enforced.

4. States may respond more rapidly to new federal laws which require state participation.

5. The legislature cannot operate effectively in fits and starts. Annual sessions thereby permit the flow of power to the executive branch.

6. Annual sessions would serve to diminish the need for special sessions.

For Annual Sessions

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For Biennial Sessions

1. There are enough laws. Biennial sessions constitute a safeguard against precipitate and unnecessary legislation.

2. Yearly meetings of the legislature will contribute to legislative harassment of the administration and its agencies.

3. The interval between sessions may be put to good advantage by individual legislators and interim study commissions, since there is never sufficient time during a session to study proposed legislation.

4. The biennial session affords legislators more time to rewrite new laws with constituents, and to conduct political elections and to campaign for reelection.

5. Annual sessions inevitably lead to a spiraling of legislative costs, for the legislators and other assembly personnel are brought together twice as often.

Several recommendations to streamline the election process were discussed and passed at the General Assembly held in Ontario on October 29, 2011. We thought you’d like to know about some of the improvements to the way we elect our leaders. A healthy discussion accompanied each of these changes prior to the vote. In some instances, amendments from the floor were addressed as well. This was a good sign as it was evidence of the interest and involvement of the members in this important process.

Plurality vote

In the future, a plurality vote will determine the winner of any vote count. What this means is that the person with the highest number of votes will be elected to the position. Why is this necessary? This will clarify what determines a winner because this is often interpreted to be a majority, that is “50% + 1". In those very rare instances where no candidate achieves the majority, it could be necessary to conduct another election round for that single race which is time consuming and expensive. Putting this provision into our bylaws clearly provides for an outright winner and does away with the expensive and delay of a re-vote.

Tie vote

A tie vote occurs when two candidates receive the same number of votes. Rather than repeating the election process, the membership voted to allow a tie vote to be determined by “lot." A lot can be achieved by any means but the most familiar one is a coin toss.

First “meeting” of the Ballot Committee

In the future, the candidate receiving the highest number of votes for the Ballot Committee will call a meeting to elect the Chair within 60 days of the biennium. The meeting may occur in many ways: face-to-face, conference call, email, or another method acceptable to the members. This will allow the new Chair of the Ballot Committee to be oriented by the previous Chair of the Ballot Committee. This will ensure that the elections process allows enough time for the Ballot Committee to become familiar with their responsibilities and begin to identify potential candidates, ensure information and consents-to-servce are made available to anyone who may decide to contribute their leadership and talents to our professional organization.

In the future, you will see other recommendations proposed by the Ballot Committee. Again, I want to extend my appreciation to our Bylaws Committee Chair, Susan Bowman for her advice and guidance, and to my fellow committee member, Marilyn Shirk for her help and support through the motion preparation and discussion.
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While there are a number of nursing programs that have invested in the high fidelity mannequins and simulation learning environments, there has been limited research on the actual learning outcomes, the simulation learning affects on students’ clinical performance, and NCLEX pass rates. As part of an overall strategy of insuring student learning, West Coast University invested in a Beta Test at its Orange County campus and researched at the following questions:

- What is the usefulness of simulation in evaluating student achievement of learning outcomes?
- Can we develop a universal tool to measure simulation learning outcomes consistently?
- What is the most effective overall simulation process to insure student learning?
- What is involved with faculty learning to administer and evaluate the simulation consistently?
- What does the simulation environment need to consist of to be effective in learning?
- Does the simulation lead to learning?
- Does the simulation education related to student success on the NCLEX?

A faculty team designed a study to investigate the selected questions. The Beta Test Research Design was implemented as follows:

- Longitudinal test A, retest A, test B, retest B design
- All students participated in groups of 8
- Scenario was randomly assigned to
  - 8 different 20 minute scenarios
  - 2 participated in scenario in hospital
  - 6 observed in debriefing room
  - Each scenario was followed by a 40 minute debriefing
  - Within 7 days after the original test day all students were randomly selected to participate in groups with new scenarios
- One of the course 20 minute scenarios that they did not participate in on the original test day.

- Module debriefing on the retest day
- Second test and retest, 1-4 weeks later with a different set of 8 scenarios- same process.
- Entire study repeated the next 10 week term with a different set of 8 different scenarios-
  - 6 observed in debriefing room
  - 2 participated in scenario in hospital
  - Each scenario was followed by a 40 minute debriefing
  - All students reported feeling more confident in their ability to use the nursing process. The nursing process factor accounted for more than 20% of the variance in the tool and was statistically significant.

We developed and are refining a universal tool that can be used in the simulation environment specifically for the scenarios. We learned how to write our own scenarios based on the course learning objectives. We are refining the tool and running further analyses. We expect to publish the tools in the near future.

We developed a simulation process focused on validated based learning to test the tool to implement this process. We found what worked best from a variety of perspectives which we expect to report on in the future. A great deal was learned about the faculty's role in the simulation process, the learning environment, and student learning. It became very clear early in the research study that dedicated faculty are needed to make a simulated clinical experience work well. It is especially important to create a hospital environment when 25% of the clinical time is in simulated experiences, the students receive a grade for the simulation experiences, and the scenarios insures all students receive the same learning opportunities.

The research data showed that simulation, when done with the rigorous learning that techniques and delivery methods, does lead to significant improvements in learning. Further research is needed to determine whether simulated clinical experiences lead to improvement in the NCLEX pass rates. Continued research efforts will offer needed information and insights. Our research results will be forthcoming in future publications.

Clinical Simulation Evaluation Tool (CSET)

- Original tool based on universal clinical evaluation tool which became a universal clinical evaluation tool (CSET).
- 33 item original scale that was later modified based on validity testing by faculty.
- The grading criteria for the first 44 students was:
  - 0= not met
  - 1= met with prompting
  - 2= met without prompting
  - This was changed with the second group to only be 0= not met and 1= met based on the validity and inter-rater reliability analysis done by faculty.
- 5 Categories initially developed based on clinical tool and NPSG & QSEN competencies.
- Faculty and researchers did content, criterion, and construct validity testing of the tool after the first group and the refined tool for group 2. Currently, the refined tool is being used and will undergo further analyses in the near future to establish the necessary reliability and validity testing for to be used as a universal tool.
- Did Reliability and Validity testing on the tool used for the Beta Testing analysis.
- The same two faculty who helped design the CSET tool with the Beta Team and were part of the Beta Test study conducted the student CSET evaluations in real time during each simulation and they were integral in the inter-rater reliability of the CSET.

The student population in this phase of the research was 88 LVN’s enrolled in an 80 week ADN bridge program. They were in their last 10 week term before graduation, taking advanced medical surgical nursing and studying for the NCLEX state exam. The student demographics were female (62), Filipino (37), Asian (20) or Hispanic (13), Black (7), white (11), other (3). The majority were single (52) or married (31) ranging in age from 20’s (46), 30’s (27), 40’s (11), and 50+ (2).

The tool was structured to reliability and validity testing. The reliability was Cronbach’s Alpha of 0.864. A factor analysis was done on the tool and it was found to have four factors which were titled in order of significance as 1- Nursing Process, 2- Clinical Judgment, 3- Professional Communication, and 4- Preparedness. Repeated measures analysis showed significant differences for all factors with increased learning from the first to fourth retest. While some significance was found with the NCLEX results, it should be considered with caution because a larger N is needed to insure reliability.

The original questions were answered in a variety of ways. Some questions were reported in statistical methods while others were reported through student and faculty feedback. The simulations were very useful in providing students a variety of learning opportunities with different scenarios. The simulations provided learning opportunities that the students do not usually have in the real life clinical situations such as using the PIXIS, administering blood products, speaking to the physicians, cardiac or respiratory arrest codes. In addition, the students learned leadership skills and how to work together in a professional manner. The clinical simulation process focused on students used more effective leadership skills in the clinical setting. The students reported feeling more confident in their ability to use the nursing process. The nursing process factor accounted for more than 20% of the variance in the tool and was statistically significant.

We developed and are refining a universal tool that can be used in the simulation environment specifically for the scenarios. We learned how to write our own scenarios based on the course learning objectives. We are refining the tool and running further analyses. We expect to publish the data in the near future.

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General Assembly

Donna Dolinar RN, Practice Board Member

ANA General Assembly was this past Saturday in Ontario at West Coast University. We had a good turn out and a great time. I always have a good time when involved nurses get together!

Kathy Falco, an ANA Practice Committee member, attended. As a reminder, Kathy works as a nurse navigator for The Spine Institute and Orthopedic Center at Glendale Adventist Medical Center. It was so great to meet her in person. I think it would be great for all of us to meet or have a conference call. I’ll work on that.

At General Assembly we dealt with bylaws, gave out awards, and toured West Coast University’s impressive nursing simulation lab. The key note speaker was ANA President Donna Dolinar RN, Practice Board Member. She talked about “Transforming Nursing: Update on IOM Future of Nursing.” Her talk was very informative. She addressed the importance of being a nurse now, the need to be at the table, and ANA’s work toward these goals.

One thing that struck me was the fact that the Future of Nursing is recommending that nurses work to the full extent of their license, plus the Affordable Care Act promotes APRNs as a resource to help with the access of care issues. As you might guess, this is making some physicians very nervous. Karen described that the IOM wanted to be proactive regarding this issue so they brought six nurse leaders, including her, and six physician leaders to the table at a meeting to iron out issues and come to a consensus about how everyone could collaborate toward the bigger goals of improving our healthcare system.

I loved that our ANA President was at the table and that a proactive approach was taking place. We will have to respond to this study as well as in California, work toward the APRN prescriptive power and independent practice legislation.

IOM & Future of Nursing & California Action Coalition (CA AC) Information: Bookmark the page to make it easy for you to access this key information.

SB 161 Diastat Update:
The governor signed the bill into law. This article gives a good overview.

ANA Executive Director Interviewed by Orange County Register:
The Orange County Register Online News published a story about the recent passing of SB 161. Ms. Hunter was interviewed and quoted. You can read the article at www.ocregister.com.

Connecting The Dots: Nursing Practice and Legislation

Donna Dolinar, MPA, BSN, RN
Director Practice Committee-ANA

Monica Weisbrich, BSN, RN
Director Legislative Committee-ANA

Nurses have a long history of effecting nursing practice through legislation. In the early 1900’s organized nursing and women’s suffrage meant gaining a political voice in the laws that regulated practice, education, and health. In the 1960’s Loretta Ford, now 90 and recently inducted into the National Women’s Hall of Fame, co-founded the nurse practitioner movement. The nurses involved in these movements saw opportunities that would lead to change in their practice.

Today with the passage and implementation of the Affordable Care Act (ACA) and the landmark report from the Institute of Medicine (IOM), The Future of Nursing: Leading Change, Advancing Health, nurses are given yet another opportunity to effect change within the healthcare systems and their own practice.

As a result of the Future of Nursing recommendations, nurses in California through the California Action Coalition (CA AC) have positioned themselves for a more active leadership role in healthcare system with a goal to practice to the full extent of their education and training. New collaborative and team-based models of care will support the goal and expand the capacity of nurses to contribute more fully to the health care delivery team.

California legislation affecting the practice of nursing wears many hats. The passage of AB 1295 provides for a seamless progression of associate degree education to the baccalaureate degree. The passage of AB 867 provides for a seamless progression of associate degree education to the baccalaureate degree. It is important to make the link between your nursing practice and the policy and legislative decisions that are being made with or without your input.

AB 867 (Nava) giving authority to the California State Universities to provide Doctorate of Nursing Practice (DNP) education and the University of California to launch the PhD programs at the Betty Irene Moore School of Nursing again facilitating Future of Nursing recommendation #5.

It is important to make the link between your nursing practice and the policy and legislative decisions that are being made with or without your input.

Legislative decisions are varied in the degree they protect the population in our State. A great deal of work is on-going to protect the consumer of healthcare—our patients—and at the same time protect our Nurse Practice Act. Much has been written about the “Insulin Bill” and the “Diastat Bill.” The “Insulin Bill” deals with litigation between the Department of Education and the American Nurses Association regarding the administration of insulin in the public schools grades K thru 12. Currently, this litigation is in the appeals court. The outcome has the potential to affect our Nurse Practice Act. The “Diastat Bill” SB 161 (Half) is similar to the “Insulin Bill” as they both deal with administration of medications in public schools grades K thru 12. The “Diastat Bill” does not affect our Nurse Practice Act because the family may contract with personnel employed in the school where their child attends to administer Diastat to their child and does not include the school nurse in the contract. On the other hand, the “Insulin Bill” legislate that the registered nurse delegates his/her authority for administration of medications to an unlicensed assistant person (UAP) who is employed by the school system. This specifically is in violation of our Nurse Practice Act. The American Nurses Association (ANA) is most grateful for the multiple letters written to the bill authors stating our concerns regarding each of these bills. The “Diastat Bill” has been signed by the Governor and we are still waiting a decision from the appeals court regarding the “Insulin Bill.”

This is an exciting time to be a nurse! Yes, we are all busy. We all have our own individual priorities in life, but we also care about advancing our profession, providing quality care to our patients, and improving the health of our nation. So let’s get excited.

It’s important to be informed and stay informed. When we say get excited, we mean get involved, join a multidisciplinary committee at your place of work, become a member of your State nursing association—ANA, run for State or Federal office. Do whatever suits you best.

As you can see, the issues can be complex. There are credible resources to help you. The goal is to have a collective voice as nurses and move toward the outcomes described in the Future of Nursing recommendations.

Change is occurring in our practice and in the healthcare system. This is an opportunity time to transform the nursing profession in order to transform health care in this country. Nurses must be empowered as a group to be at the table and influence those changes. Many nurses came before us and used their voices to impact health care delivery and the advancement of the nursing profession. It’s our time.

WILL YOU BE AT THE TABLE?

Resources:
http://www.anacalifornia.org ANAC
http://www.facebook.com/pages/American-Nurse-Association-California
http://www.anacalifornia.org/ana/navas
http://thefutureofnursing.org Future of Nursing: Campaign for Action
http://www.twitter.com/futureofnursing
http://www.facebook.com/futureofnursing
http://thefutureofnursing.org

WILL YOU BE AT THE TABLE?
ANA Advocacy Institute Grant Winner

ANA Legislative Committee Member, Candace Campbell, MSN-HCSM, RN is the CA recipient of the 2011-2012 ANA Advocacy Institute (ANAAI) grant. The select group of 21 mentees from across the US, convened October 1-4, in Washington, DC, to study current national legislation which may effect the nursing profession and public health. “We brain-stormed how to best influence legislators with our ANA membership’s support or oppose positions,” said Campbell, who works as NICU staff nurse and educator within the John Muir Health system, as well as adjunct faculty at University of San Francisco, and CSU EB.

The conference included talks by the Honorable Minnesota State Legislature Assistant Minority Leader (and ANAAI mentor), Erin Murphy, MA, RN, who spoke on setting realistic goals, and how nurses can use the Plan-Do-Study-Act system to positively influence legislators. Other ANAAI program mentors, include the Honorable Mary Behrens, NP, RN (Wyoming), Susan Clark, RN (lobbyist from Illinois) and Shaun Flynn, RN, Director of ANA/NY, who presented information on navigating the political system at home, and in DC. A team from a Washington-based public relations firm offered information about how to craft a message for legislators, regulators and the media.

“Thanks to the IOM 2010 Future of Nursing report, nurses have unprecedented opportunities to make our voices heard, and to influence legislation, this year and for the future,” Campbell offered. “ANA leaders are busy contacting legislators. The focus this year is to pass legislation which will allow nurses to practice within the full extent of the law and of their education. That battle has to take place state-by-state, and every member can help in your own region.”

The grant term is one year, during which time Campbell will pool ideas and study policy issues, write papers and articles, and report to the ANA through monthly teleseminars. “Our work generally takes place online, or in person,” she stated. At this time, Campbell is scheduled to return to Washington, DC in June 2012 as one of six CA delegates to the ANA Congress, where strategic association planning/resolutions for the next two years takes place.

The conference highlight was a day of lobbying on capitol hill with selected legislators (see photo).
Halloween is four weeks away, but infectious disease researchers already have a scary story to tell. They say healthcare workers who wash their uniforms in domestic washing machines might not kill MRSA and other infectious organisms.

After washing their scrubs with detergent, they also may need to iron them to avoid carrying bugs such as Acinetobacter back to their patients.

This may not have been necessary in the past. But two events have altered the landscape on this topic, say John Holton and colleagues at the University College in London, whose report is published in the latest issue of Infection Control and Hospital Epidemiology.

First, changing standards that have lowered household water temperatures and constrain the use of water to save energy and resources “may influence the risk of nurses’ uniforms being inadequately laundered” under home circumstances, they said.

And second, at least in the UK, many hospitals no longer provide in-house laundry service because of a “reorganization” of the National Health Service. Now, nurses launder their uniforms or scrubs at home or in public laundromats.

The researchers produced a table that showed the ability of a typical washing machine to reduce the presence of Methicillin-resistant Staphylococcus aureus and Acinetobacter baumannii typically found on nurses’ uniforms after one day of use. They examined a variety of temperatures and hot water exposure times from 86 degrees Fahrenheit and 10 minutes exposure to 194 degrees and 3 minutes exposure.

Not until temperatures reached 140 degrees, with 10 minutes of water exposure time, were organisms said to be eradicated, the study said. At 104 degrees Fahrenheit, however, while MRSA was eliminated, colonies of Acinetobacter remained. The researchers found that ironing fabric eliminated the Acinetobacter.

Use of detergent was more effective at reducing colonies than not using detergent, they wrote.

The researchers also pointed out the possibility that the washing machines themselves may harbor infectious material from washing load to load, and that clothing not contaminated going in might become contaminated during the process.

The researchers did not examine the impact of a tumble dry cycle in an electric dryer.

“The results of this study suggest that a detergent should be included when laundering nurses’ uniforms, and, also, as lower temperatures and lower water use is likely to increase, particular attention should be paid to the organisms colonizing washing machines after laundering hospital uniforms,” they concluded.

The researchers said they have other projects to expand information available about hospital-acquired contaminants. They want to determine how infectious organisms may become established in the biofilm of a washing machine, assess the effect of other detergents on various types of bacteria and look at how a variety of fabrics used in patient care resist disinfection efforts.

The report is the latest to examine the threat of hospital-acquired infections from clothing, jewelry and accessories, from shoes to earrings and neckties, even as some hospitals in the UK and in the United States shift to policies that ban long-sleeved lab coats and shirts.

In May, the New York State Legislature was considering a bill that would set up a “Hygienic Dress Code Council” appointed by the Health Commissioner to advise on banning clothing and accessories in healthcare settings.

And in September, Jerusalem researchers found half of uniforms worn by nurses and doctors were infected with pathogenic bacteria that collected in the abdomen area and on the sleeves.

Other efforts to control transmission of bacteria within healthcare settings to patients have included a short-lived effort in Canada to ban toys and magazines in hospital waiting areas unless the patient or family members and friends brought them in and take them away when they leave.

Hospitals are under the gun to do everything they can to reduce healthcare associated infections or face a downward adjustment on their Medicare DRG payments, according to parts of the Patient Protection and Affordable Care Act.

Cheryl Clark is a senior editor and California correspondent for HealthLeaders Media Online. She can be reached at cclark@healthleadersmedia.com.
The holiday decorations are going up in my neighborhood, Thanksgiving is next week, and my mind could have expected. Of 2010 and much of this year has been spent digesting its changes hit nursing. In addition, the column a little early this year. I thought I’d turn in the annual retrospective/prediction for what’s in store in 2012. With these things on my mind, I feel engaged in the process, involved in the plans, and need to feel ownership for patient safety as well. I wrote last month that “quality improvement becomes one more meaningless directive from ‘above’ unless nurses feel engaged in the process, involved in the plans, and accountable for the results.”

1. Advanced degrees are no longer optional I have been cheered that discussion of the IOM’s recommendation for 80% of all RNs to have a baccalaureate degree by 2020 has not veered too intensely into the old ADN vs. BSN quagmire. Instead, the profession is focusing on ways to engage nurses in lifelong learning so that associate degree nurses can find realistic ways to obtain BSN degrees. In addition, BSN nurses are encouraged to be leaders in evidence-based practice and research and it’s becoming more common—and crucially, more expected—for nurses to pursue master degrees. And the creation of the doctor of nursing practice degree has taken off better than anyone could have expected.

In the last six months, any time I’m in a group of nurse executives, the conversation always turns to who has already entered a program and how long it’s going to take the rest of the group to do so.

2. Patient engagement gets real If you haven’t found a way to drive home the importance of patient experience to direct-care nurses, find it now. You know how much reimbursement is at stake, but the rank and file caregivers still don’t get it. I’ve written before that the term “patient experience” has a way of annoying bedside caregivers. “We’re not Disneyworld,” is a common refrain; people don’t want to be in the hospital. “I’m here to save patients’ lives, not entertain them,” is another common complaint.

Experience isn’t about mollycoddling patients, however, or how flashy the in-room entertainment system is and that’s what you need to help nurses understand. In fact, the nurse-patient relationship has always been about patient experience. Your best nurses instinctively know this. They already create a good patient experience. They help patients understand their care, involve families in decision-making, coordinate multidisciplinary care, sit with patients after discharge and these letters are all about the patient experience.

This is how you need to phrase patient experience with nursing staff so they understand it’s not just a program, but a way of life. At the same time, nursing needs to own the cause. They may not be responsible for it in isolation, but they are literally at the center of this issue. They should take the lead and drive the agenda.

In this column from September, I outlined 10 ways to help nurses improve patient satisfaction.

3. Patient safety Just as nurses should own patient experience, they need to own ownership of patient safety as well. I wrote last month that “quality improvement becomes one more meaningless directive from ‘above’ unless nurses feel engaged in the process, involved in the plans, and accountable for the results.” Preventing healthcare-associated infections (HAI) is no longer simply the right thing to do, it’s become the only financially viable option. Unless nurses are educated and empowered, real progress cannot be made.

4. Cost cutting Nurse retention is a constant threat and healthcare organizations are forced to put cost cutting at the top of the agenda in 2012. As the largest budget in the organization, nursing is an easy target.

Organizations can get more agile with staffing and scheduling and find creative ways to reduce cost while maximizing efficiency. Embrace change and flexibility to create the mobile, agile workforce healthcare organizations need to adapt to changing economic realities and increases in patient population.

At the same time, staffing budgets can’t be viewed in isolation. There are direct links between nurse staffing and length of stay, patient mortality, readmissions, adverse events, fatigue-related errors, patient satisfaction, employee satisfaction, and turnover. This article examines the danger of considering the cost of nurse staffing without looking at everything else. It’s important to understand the relationship between length of stay, unreimbursed never events, and nurse staffing to understand the whole picture.

5. Retention I’ve said it before, but ignore retention at your peril. The nursing shortage hasn’t gone away simply because the recession has eased its immediate effects. We all know the turnover rate for new graduate nurses is always high, so invest in nurse residency programs that have proven results for retention and for increasing the competency of new nurses.

Take a look at the five reasons nurses want to leave your hospital and see whether you’re doing any of these.

Rebecca Hendren is a senior managing editor at HCPro, Inc. in Danvers, MA. She edits www.StrategiesForNurseManagers.com and manages The Leaders’ Lounge blog for nurse managers. Email her at rhendren@hcpro.com.
Membership and Communication

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