President’s Perspective

By the time you see this article our country will have elected the next President of the United States—an historical moment in time! Leaders call upon and rely upon us to help make positive change. Whether we each may have differing political leanings, ANA and ANAC have been committed to supporting those leaders in the highest offices; to working with them to improve healthcare for all.

Greetings…

Leadership at ANAC: It has been a very busy and fulfilling time as President of ANAC/California—with much listening, looking and learning. There have been many practice, policy and legislative activities, with ANAC in the forefront of promoting high quality and access to healthcare. ANAC was invited to numerous events, including the governor’s bill signings; hearings, healthcare events, and the 2012 ANCC Magnet Conference in Los Angeles, in October (please see the article in this newsletter). Over the years, ANAC has become more and more connected with the California Nursing Students Association. We participated at their 2012 convention in Irvine. Many students came to our booth and met ANAC members who talked with them about nursing, and association involvement. ANAC is fortunate to be working with CNSA and ACNL to support nursing students. On an exciting note, recent graduates have run for and been elected to the ANAC board. The combined perspective and work of those with many years in nursing and those newer to the profession, is an invaluable contribution to our success.

On leadership and associations: Those of you who have been in association leadership positions appreciate the responsibility and the “feeling” of responsibility that goes with the position. Whether leading meetings, attending ANA meetings, or participating in statewide or local events, that “obligation” is with you wherever you are. Ask for and treasure the support from those whom you lead and with whom you work. Do not go it alone; accomplishments are best when shared.

If considering running for an office of any kind, plan to be busy and to feel that sense of responsibility and accountability. Think about what you want to do and when—timing is important. Nurses tend to be busy people who want to do more, and often have a difficult time saying no. You will likely realize when the right time is for you to add your name to a ballot, to volunteer, because you believe you can—and want—to do the job.

Open communication and transparency, words of the 21st century—make things work. A nurse in an association executive position once said, in so many words: “... power is in the sharing of information, not in keeping it to yourself.” There is much wisdom and truth in that phrase and a guide for those in leadership positions.

Be alert to nursing career opportunities and find a colleague, a mentor, with whom you can talk.

“UNLESS someone like you Cares a whole awful lot,
Nothing is going to get better.
It’s not.” —the Lorax —Dr. Seuss

Again, with more than 360,000 nurses in California, there is a huge chance for you to make a difference. My repeated plea: get involved at the local, state, national and/or international levels.

Please become involved! Join committees, become active in community groups, precept, mentor, teach, or at least join email lists that match your interests. Consider working on CA AC activities.

Ongoing state: A Future of Nursing Update: Members of ANAC and other nurses are involved with the California Action Coalition—the Statewide CA AC and local groups, are working together to address nursing’s future in California. ANACalifornia continues to have strong representative leadership in the CA ACs, regionally and statewide. As the Los Angeles Regional Area Co-Leader, along with Dr. Rosie Curtis, we continue working on opportunities to become active participants in positive change. [Reference: The Future of Nursing: Leading Change, Advancing Health, by the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine; (2011)].

Ongoing national: Affordable Care Act, other healthcare initiatives. State Presidents and Executive Directors have regular calls with the ANA President, and regional groups.

View the American Nurses Association/California website and the American Nurses Association website (nursingworld.org), as well as the California Action Coalition website. You will find information about issues such as: BRN updates; legislation, events and state and national issues, Health Care Reform; bills related to nursing practice, and more. We try to keep you updated.

Please maintain your ANAC membership or join if you have not. We are constantly growing thanks to the Nurses in California. ANAC is the professional nurses association in California open to all RNs, in all types of roles at all types of settings. If you can, join at least two associations—your professional general organization—ANA/California, and your specialty organization. The networking and knowledge gained are most worthwhile.

Review of ANAC structure: We have 4 elected officers, President, Vice-President, Secretary and Treasurer, with clear responsibilities; and 4 elected Board Directors, each with a specific focus, i.e., Practice, Legislation, Education, and Membership. The Board works together, promoting a strong association dedicated to Nursing and improving healthcare. Nurses can be involved either on committees with the Directors or at least on their e-mail groups. Some groups have only ANAC members, others include nonmember nurses. Those who vote must be ANAC members. Please contact...
Article Submittal to ‘The Nursing Voice’

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 there is space available, ANA 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, 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

2. Photographs 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 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 themusingvoice@yahoo.com

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

ANA California

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

2. Photographs 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 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 themusingvoice@yahoo.com

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

Let us help you pay for your graduate education

PICK YOURSELF at the Betty Irene Moore School of Nursing at UC Davis—a new nursing school with a vision to advance health and ignite leadership through innovative education, transformative research and bold system change.

SPACE IS LIMITED! APPLICATIONS ARE NOW OPEN FOR FALL 2013 classes in the M.S. and Ph.D. interprofessional Nursing Science and Health-Care Leadership Degree Programs.

Defend Your License!

UCDavis
BETTY IRENE MOORE SCHOOL OF NURSING
nursing.ucdavis.edu

www.anacalifornia.org

Published by: Arthur L. Davis
Publishing Agency, Inc.

DEFEND YOUR LICENSE! • Have you recently been arrested for driving under the influence of some other criminal matter? • Have the Board of Registered Nursing recently started an investigation into your license? Don’t wait until your license has been revoked or suspended for an administrative hearing – CONTACT KELLY BABINEAU – now! If the answer is yes, you have the best defense possible. This is your livelihood, don’t wait.

THE LAST DEFENSE OF KELLY BABINEAU
EDUCATION – ATTORNEY – LICENSED RN
301 H Street, Ste 203
Sacramento, CA 95814
916-442-4948
www.babineaulegal.com

American Nurses Association/California is an Affiliate Chapter Member of the American Nurses Association.

The Nursing Voice is the official publication of the American Nurses’ Association/California.

ANA is located at
1121 L. Street, Suite 409
Sacramento, CA 95814.
Office 916-447-0225 - Fax 916-442-4394
Association E-mail ana@anacalifornia.org
The Nursing Voice Editor E-mail themusingvoice@anacalifornia.org

ANA BOARD OF DIRECTORS Officers: Elissa Brown, MSN, PMHCNS-BC, President; Elizabeth “Liz” Dietz, EdD, RN, CS-HP, Vice President, Nicole Marcy, BPH, BSN, RN, Secretary; Cathy Meher, MSN, CWOCN, Treasurer; Directors: Monica Weirich, BSN, RN, Legislative and Professional; Donna Dolinar, RN, BSN, MPA, Practice; Dianne Moore, PhD, RN, CNM, MN, MPH, Education; Angela Schwab, BSN, RN, Membership and Communication.

ANA California
Executive Director: Hon. Tricia Hunter, MN, RN
ANA California Lobbying Firm: Government Relations Group, Inc.
ANA Director of Member Services: Samantha Hunter
ANA Merchandise Development & Sales: Michele Townsend
Editorial Committee: Chairperson: Louise F. Timmer, EdD, RN
Staff: Hon. Tricia Hunter, MN, RN
Samantha Hunter

The official publication of the ANA will be The Nursing Voice. The purpose of this publication shall be to support the mission of ANA through the communication of nursing issues, continuing education and significant events of interest. The statements and opinions expressed herein are those of the individual authors and do not necessarily represent the opinion or views of ANA; it’s staff, the Board of Directors, its affiliates or the publications editors. Likewise, the appearance of advertisers, and/or their views and opinions, do not constitute an endorsement of products or services featured in this, past or subsequent issues of this publication. Copyright by the American Nurses Association/California.

The Nursing Voice is published quarterly every January, April, July and October and is complimentary to ANA members, schools of nursing and their nursing students, affiliates of the association and their memberships. If you would like to submit an article for publication, please see ‘Article Submission for The Nursing Voice’ in this issue for deadlines and submission details.

If you would like to receive this publication or you would like to stop receiving this publication please write or call the ANA at 916-447-0225 or fax (916) 442-4394. Please leave your full name, complete address or address correction and a phone number should we need to contact you. Or, fill out and mail in the Update Request Form found in this newsletter.

Regrets and Submission: ANA allows reprints of newsletter material. Permission requests should be directed to the ANA home office in Sacramento, CA 95814.

Advertising: Advertising Rates Contact—Arthur L. Davis Publishing Agency, Inc. 517 Washington St., PO Box 216, Cedar Falls, IA 50613, 800-626-4081, sales@adpub.com. ANA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement. Acceptance of advertising does not imply endorsement or approval by ANA of products advertised, the advertisers, or the claims made. Rejection of an advertisement does not imply a product offered for advertising is without merit, or that the manufacturer lacks integrity, or that this association disapproves of the product or its use. ANA and the Arthur L. Davis Publishing Agency, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser’s product.
Elissa Brown, Nicole and Pat McFarland

Pippa White, a wonderful storyteller, who played Florence Nightingale, Dorothea Dix and Clara Barton—with excerpts from actual writings of these historic nurses. She was excellent!

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

President’s Perspective continued from page 1

At ANA/C, our members and staff work diligently toward excellence in Nursing practice, in promoting high quality healthcare, in influencing legislation and regulation, in participating in healthcare reform activities, in promoting the Nursing profession and supporting ANA/C and ANA.

Thank you to all Nurses for what you do to provide high quality health care for patients, families, and communities. Be good to each other and to yourselves! Have a Happy Holiday season!

ANA/C California invites comments, questions and suggestions from our members and others. Let us know what more you would like from us and for us to be doing.

17% of the dues paid by ANA/C and ANA members for 2012 are for lobbying expenses, which is not deductible as a business expense.

Commit to making a greater impact.

Fast-track your career with one of Chamberlain’s CCNE accredited* advanced nursing degrees. RNs, you can complete your BSN in as few as three semesters, with no on-site clinical requirements. Or go further by completing the Master of Science in Nursing Degree Program in just two years. These flexible, online programs are supported with faculty focused on student success. Make a greater impact with an advanced degree from Chamberlain.

Be a Chamberlain Nurse.
ANCC Magnet Conference  
October 10 - 12, 2012

Elissa Brown, ANAC President & Hon. Tricia Hunter, ANAC Executive Director

As President and Executive Director of ANAC, California, we were honored to attend the 2012 American Nurses Credentialing Center (ANCC) Magnet Conference in Los Angeles. Thousands of nurses from all over the country, and from all over the world were there at the Los Angeles Convention Center. The annual convention is an opportunity for magnet hospitals, staff and future magnet participants to attend presentations, view poster exhibits and meet with exhibitors that support the magnet agenda.

We were able to go to special events, the exhibits, and educational sessions. The opening ceremony included recognizing The Nurses Float, as a key not-for-profit event, which everyone was encouraged to help with the fundraising and decorating the float for the annual Rose Bowl Parade. Melissa Gilbert shared her experience as a mother with her child in UCLA Children’s Hospital. The founders of the Daisy Award discussed how every nurse they honored stated “they were just doing their job.” They thanked nurses for “just doing their job.” During the business meeting every hospital that had received Magnet Status, or renewed their status was recognized. There were large numbers of nurses from each one of these facilities in attendance. After a moving presentation about each facility, the staff in the audience was recognized. Many of them marched around the meeting room. Some of them wore T-shirts and distributed a gift to the audience after the presentation. ANA President, Karen Daley, and CEO, Marla Weston, were recognized. They were present at most of the opening events. They each set up times for attendees to come and talk with them. Many of our ANA California colleagues were there; some were presenters, some were volunteers, some were there with their Magnet facilities, and some were there as exhibitors.

There was a wide range of topics presented. A hospital in the Midwest presented about meeting the goal of 80% BSN staff. Their presentation included what the hospital had done to support the working nurse to get her degree as well as hiring policies that would help them reach the goal. The new hire ADN graduate had a number of years to obtain their BSN, with the hospitals help. Other presentations included ethics, research, preventing patient injury and stories about how the hospitals were meeting the different goals of Magnet accreditation.

The exhibit hall was filled with vendors and groups that were involved with the Magnet Facility process. There were numerous tools for staffing; portable desks for nurses to chart; many schools with BSN, MSN and Doctorate programs, nursing associations such as AORN and Sigma Theta Tau and not-for-profit organization booths like Nurses for the Float.

ANA had a wonderful booth where ANAC members helped and did a great job for ANA and ANACalifornia. ANCC gave a special recognition to the Flowers for the Float which made the attendees more aware of the float—and the ANAC members who are on the Flowers for the Float Board. Many nurses from other countries came to the booth to talk with us, as well.

The entire conference was excellent, including recognition of all the Magnet Facilities, special awards, and the entertainment. By the way, entertainment included: a brief spot by Cirque de Solei, film and TV stars addressing the audience and thanking nurses for all we do; music and, dancers from the TV show Glee, choirs, orchestras, etc.—in true “Hollywood” fashion, of course.

We thank ANA and ANCC for inviting us.
Further information:
www.ethicsofcaring.org

Faculty
Katherine Brown-Saltzman, MA, RN
Co-director, UCLA Health System Ethics Center
Assistant Clinical Professor, UCLA School of Nursing
Los Angeles, California

Theresa Drought, PhD, RN
Director of Bioethics, Woodland Hills Medical Center
Kaiser Foundation Hospitals and Health Plan
Woodland Hills, California

Cynda Hylton Rushton PhD, RN, FAAN
Professor of Nursing, Pediatrics and Bioethics - Johns Hopkins University and Children’s Center
Baltimore, Maryland

Tilda Shalof RN, BScN, CNCC (C)
Toronto General Hospital
Toronto, Ontario Canada

Sarah E. Shannon, PhD, RN
Associate Professor, Biobehavioral Nursing & Health Systems, School of Nursing, University of Washington
Adjacent, Bioethics & Humanities
School of Medicine, University of Washington
Clinical Ethicist, University of Washington
Medical Center,
Seattle, Washington

Carol Taylor, PhD, RN
Professor, Georgetown University School of Nursing and Health Studies Senior Faculty,
Georgetown University Kennedy Institute of Ethics
Washington DC

Lucia D. Wocial, PhD, RN
Nurse Ethicist, Indiana University Health
Adjunct Assistant Professor,
Indiana University School of Nursing
Indianapolis, Indiana

See webpage for additional faculty
Poster Sessions
Deadline for Poster Abstract Submission is 11/26/12
https://ana.confex.com/ana/nnec13/poster/papers/index.cgi

Day One
Opening – Caring – The Core of Nursing Ethics

Keynote Speaker
Why Patient Advocacy is Hurting Patients

Plenary
The Power (and Limits) of One

Breakout Topics
• When Something Bad Happens: Disclosing Errors as an Ethical Practice
• Cultivating Compassion: Caring for the “Difficult” Patient or Family

Closing
Opening My Heart – The Risks and Benefits of Opening Yours

Day Two
Keynote Speaker
Breaking the Silence: Every Nurse’s Moment of Truth

Plenary
The Privilege of Bearing Witness

Case Discussions

Breakout Topics
• Cultural Humility
• Ethics of Caring in Co-worker Relationships – No Place for Bullies, Victims or Bystanders
• Ethics Support: Models for Nurses at the Bedside
• Leading Change from the bedside
• Connecting Values in the Context of Futility Treatment
• Resources to Support Ethical Practice in End of Life Care

Closing
Transforming Moral Distress into Healing and Resilience
The legislative year was a difficult one. For the first time, that I can remember, we had multiple nursing groups over legislation. The California Nurses Association (CNA) has taken a position against the goals of the Institute of Medicine Report on Nursing. This position includes opposing legislation that advances the practice of a Registered Nurse or an Advanced Practice Nurse. We had two bills that the American Nurses Association/California (ANA/C) and CNA were on the opposite side of the issue around practice.

ANA/C and United Nurses Association of California (UNAC) supported legislation by Planned Parenthood Procedure, to dispense birth control pills. This legislation that allowed the Registered Nurse, under Standardized Procedure, to pass and was signed into law. Assemblywoman Mitchell carried the bill and joined us at a bill signing ceremony with Governor Brown. ANA/C President Elissa Brown represented us at the event.

ANA/C strongly supports removing barriers that are not in the Nurse Practice Act (NPA) to allow nurses to practice to the full extent allowed by law. Another bill would have removed a statute making it a felony for anyone but a medical doctor to provide a therapeutic abortion. Under the NPA, a Registered Nurse can expand our practice using standardized procedure with the agreement of the nurse, medical director and the facility. When statutes are passed in other codes we are blocked from practice. There are numerous examples of this.

Open-ended mandates—Physical Therapists, Occupational Therapists and others to support legislation that would require insurance companies to accept providers who were licensed to provide the care approved by the board. This bill was supported by the California Nurse Midwives and the California Association of Nurse Anesthetists. The goal is part of the Obama Healthcare Plan. The Governor vetoed the bill with the caveat that he wanted to see the federal regulations first.

ANA/C provided testimony on bills that set up standards for hospice care, provided licensure, credentialing, or title protection for a number of occupations.

The legislative committee was very busy this year. As the lobbyist for ANA/C I want to thank all of the members for their input on some tough legislation!


AB 24 AUTHOR: Block. (D) TITLE: Postsecondary Education Commission: Study—Chula Vista INTRODUCED: 12/06/2010 DISPOSITION: Failed
SUMMARY: Amends existing law that establishes the Postsecondary Education Commission. Requires the commission to complete a study and make recommendations concerning the feasibility of establishing and expanding postsecondary education opportunities in Chula Vista.
STATUS: 02/01/2012 Died pursuant to Art. IV, Sec. 10(c) of the Constitution.

LOCATION: Chaptered
SUMMARY: Requires a school district that elects to offer athletic programs to remove from an activity an athlete who is suspected of sustaining a concussion or head injury. Prohibits the return of the athlete until he or she is evaluated, and receives written clearance from a licensed health care provider. Requires an annual related information sheet to be signed and returned by the athlete and his or her parent or guardian before practice or participation. Exempts activity in a physical education course.

CA AB 30 AUTHOR: Hayashi (D) TITLE: Health Facilities: Security Plans INTRODUCED: 12/06/2010 LAST AMEND: 03/14/2011 SUMMARY: Amends existing law relating to hospital security plans. Requires a hospital to evaluate and treat an employee who is involved in a violent incident. Provides a civil penalty for not reporting. Prohibits a hospital from prohibiting an employee from seeking assistance from local emergency services or law enforcement when a violent incident occurs. Makes changes concerning reporting of a firearm, hospital inspections, training for hospital employees who are regularly assigned to the emergency department.
STATUS: 02/01/2012 Died pursuant to Art. IV, Sec. 10(c) of the Constitution.

CA AB 604 AUTHOR: Skinner (D) TITLE: Needle Exchange Programs INTRODUCED: 02/16/2011 ENACTED: 10/09/2011 DISPOSITION: Enacted
SUMMARY: Authorizes the State Department of Public Health to authorize certain entities to provide hypodermic needle and syringe exchange services in any location where the department determines the conditions exist for the rapid spread of HIV, viral hepatitis, or any other potentially deadly or disabling infections spread by use of such needles and syringes. Requires the placement of related information on the department’s Web site. Exempts project volunteers from prosecution. Relates to reporting requirements.
STATUS: 10/09/2011 Signed by GOVERNOR.

CA AB 1453 AUTHOR: Monning (D) TITLE: Health Care Coverage: Essential Health Benefits INTRODUCED: 05/05/2012 ENACTED: 09/30/2012 DISPOSITION: Enacted
SUMMARY: Requires an individual or small group health care service plan contract issued, amended, or renewed, to cover essential health benefits to include the health benefits covered by particular benchmark plans. Prohibits substitutions of benefits covered. Prohibits treatment limits imposed on benefits from exceeding the corresponding limits imposed by benchmark plans. Prohibits a plan from making substitutions of the benefits required to be covered. Authorizes emergency regulations implementing these provisions.
STATUS: 09/30/2012 Chaptered by Secretary of State. Chapter No. 854

CA AB 1588 AUTHOR: Atkins (D) TITLE: Professions and Vocations: Restorative Licensees INTRODUCED: 02/22/2012 ENACTED: 09/30/2012 DISPOSITION: Enacted
SUMMARY: Requires boards within the Department of Consumer Affairs to waive renewal fees, continuing education and other renewal requirements as determined by the board, of any licensee or registrant who is recalled to active duty as a member of the Armed Forces or the California National Guard if certain requirements are met. Prohibits any activities while waive the is in effect. Requires a licensee or registrant to meet renewal requirements after discharge and prior to engaging in activity requiring a license.
STATUS: 09/29/2012 Chaptered by Secretary of State. Chapter No. 742

CA AB 1867 AUTHOR: Pan (D) TITLE: Health Facilities: Equipment Standards INTRODUCED: 02/22/2012 ENACTED: 08/27/2012 DISPOSITION: Enacted
SUMMARY: Relates to provisions of existing law prohibiting certain health facilities from using an intravenous or enteral connection that would fit into a connection port other than the type for which it was designed. Requires use of federal Centers for Disease Controls and Prevention’s Advisory Committee on Immunization Practices in the absence of department guidance. Revises the provisions to prohibit to refer epidural, intravenous, and enteral connectors.
STATUS: 08/27/2012 Signed by GOVERNOR.

CA AB 2009 AUTHOR: Galgiani (D) TITLE: Communicable Disease: Influenza Vaccinations INTRODUCED: 02/23/2012 ENACTED: 09/23/2012 DISPOSITION: Enacted
SUMMARY: Authorizes the State Department of Public Health to provide flu vaccine to specified entities at no charge so that the entities may provide the vaccine to specified high risk groups. Allows the department to provide guidance regarding priority groups. Requires use of federal Centers for Disease Controls and Prevention’s Advisory Committee on Immunization Practices in the absence of department guidance. Requires non-profit’s liability. Authorizes vaccine for other respiratory infections.
STATUS: 09/22/2012 Chaptered by Secretary of State. Chapter No. 443

SUMMARY: This bill would delete the requirement for at least 6 months’ duration of supervised experience. The bill would authorize a physician and surgeon to determine the extent of the supervision in connection with the furnishing or ordering of drugs and devices by a nurse practitioner or certified nurse midwife.
Chaptered by Secretary of State. Chapter 796, Statutes
of surgical clinics, outpatient surgical and in vitro fertilization setting accreditation and public notification thereof, outpatient setting accreditation agency approval, and the investigation of outpatient setting violation or noncompliance.

STATUS: 10/09/2011 Chaptered by Secretary of State.
Chapter No. 645

CA SB 135 AUTHOR: Hernandez E (D) TITLE: Hospice Facilities
INTRODUCED: 03/01/2011
ENACTED: 02/10/2011
DISPOSITION: Enacted
SUMMARY: Establishes a new health facility licensing category for hospice facilities. Requires the Department of Public Health to develop regulations governing the licensure of those facilities. Imposes various requirements on these facilities. Excludes a freestanding building used as a congregated living facility or as a hospice facility from the definition of a hospital in existing law.
STATUS: 09/27/2012 Chaptered by Secretary of State.
Chapter No. 789

We supported this bill initially and then moved to oppose when the RN requirements were removed. We were successful in getting the bill amended to include staffing criteria.

CA SB 393 AUTHOR: Hernandez E (D) TITLE: Patient-Centered Medical Homes
INTRODUCED: 02/16/2011
VETOED: 09/30/2011
DISPOSITION: Vetoed
SUMMARY: Establishes the Patient-Centered Medical Home Act of 2012. Defines patient-centered medical home. Provides that a physician-directed practice team shall not be construed to prohibit activities conducted pursuant to specified provisions of law regarding scope of practice.
STATUS: 09/30/2012 Vetoed by GOVERNOR.

This bill is supported by the California Family Practice Physicians. We started out supporting and moved to a watch position when the stronger language about being physician-driven was added.

SB 98 AUTHOR: Price (D) TITLE: Nursing BRN SUNSET BILL
INTRODUCED: 01/10/2012
ENACTED: 02/24/2012
SUMMARY: A budget bill to reinstate the Board of Registered Nursing after the board was sunset in 2011. This bill included allowing the Board to hire the Executive Director, measures to stagger the appointments of the members, authorizing the board to spend its funds, and other actions that assured the boards continuance.
STATUS: 2/14/2012 Signed into law by Governor

CA SB 538 AUTHOR: Price (D) TITLE: Nursing BVNPT SUNSET BILL
INTRODUCED: 02/17/2011
VETOED: 10/09/2011
DISPOSITION: Vetoed
LOCATION: Vetoed
SUMMARY: Extends the operation of the Board of Vocational Nursing and Psychiatric Technicians. Requires an applicant for a licensed vocational nurse or psychiatric technician’s license to have completed specified courses from an approved school. Relates to the inspection of such schools. Requires an employer, employment agency or nursing registry to report the resignation for cause or the rejection from assignment of a licensed vocational nurse or psychiatric technician. Specifies that a violation is a misdemeanor.
STATUS: 09/26/2011 Signed by GOVERNOR.

CA SB 690 AUTHOR: Hernandez E (D) TITLE: Health Care Coverage: Discrimination
INTRODUCED: 02/18/2011
LAST AMEND: 06/18/2012
DISPOSITION: Failed –Adjudged
LOCATION: Assembly Appropriations Committee
SUMMARY: Requires an employer to develop and implement a plan for health care service plan or health insurance covering discrimination.

ANAC supported this bill along with CPR allies. This bill was very important to all of us. It is part of the Obama Health Care Reform. The Governor stated he wanted to wait until regulations were written by the Federal Government.

CA SB 510 AUTHOR: Price (D) TITLE: Nursing BRN SUNSET BILL
INTRODUCED: 02/17/2011
ENACTED: 09/26/2011
DISPOSITION: Enacted
SUMMARY: Extends the operation of the Board of Vocational Nursing and Psychiatric Technicians. Requires an applicant for a licensed vocational nurse or psychiatric technician’s license to have completed specified courses from an approved school. Relates to the inspection of such schools. Requires an employer, employment agency or nursing registry to report the resignation for cause or the rejection from assignment of a licensed vocational nurse or psychiatric technician. Specifies that a violation is a misdemeanor.

CA SB 690 AUTHOR: Hernandez E (D) TITLE: Health Care Coverage: Discrimination
INTRODUCED: 02/18/2011
LAST AMEND: 02/01/2012
DISPOSITION: Failed
LOCATION: SENATE
SUMMARY: Requires the Department of Public Health to develop regulations governing the licensure of such school.

This bill died on the Senate Floor.

CA SB 924 AUTHOR: Price (D) TITLE: Physical Therapists: Direct Access to Services
INTRODUCED: 02/18/2011
LAST AMEND: 08/24/2012
DISPOSITION: Failed –Adjudged
SUMMARY: Authorizes patients to access physical therapy directly. Requires a physical therapist to refer a patient to another healing arts practitioner if the patient requires treatment or service beyond that scope of practice, and with authorization, to notify the patient’s physician and surgeon the therapist is treating the patient. Prohibits a physical therapist from treating a patient beyond a specified scope, unless certain conditions are met. Relates to professional corporations and a chiropractic corporation.

CA SB 951 AUTHOR: Hernandez E (D) TITLE: Health Care Coverage: Essential Health Benefits
INTRODUCED: 01/05/2012
LAST AMEND: 03/30/2012
DISPOSITION: Enacted
SUMMARY: Requires an individual or small group health care service plan contract or health insurance policy to cover specified essential benefits, regardless of whether or not the contract or policy is offered through the Health Benefits Exchange. Excludes grandfathered plans or existing contracts. Prohibits the exclusion of any essential benefits unless it covers benefits as covered in this bill. Prohibits treatment limits from exceeding corresponding limits. Prohibits substitutions.
2012 Oppose Bills

CA AB 352 AUTHOR: Eng (D) TITLE: Radiologist Assistants FISCAL COMMITTEE: yes URGENCY CLAUSE: no STATUS: 02/01/2011 LAST AMEND: 04/03/2012 DISPOSITION: Failed SUMMARY: Amends existing law that authorizes the CURES program that provides for the electronic monitoring of the prescribed and dispensing of Schedule II, Schedule II, and Schedule IV controlled substances by all authorized prescribers. Requires increased license fees for dentists, pharmacists, nurses, veterinarians, nurses, osteopaths, optometrists and pilots if funding is insufficient.
STATUS: 08/29/2012 In ASSEMBLY Committee on BUSINESS, PROFESSIONS & CONSUMER PROTECTION; Failed passage.

CA AB 675 AUTHOR: Hugman (R) TITLE: Continuing Education Intro. 02/17/2011 Last Amend: 04/05/2011 Disposition: Failed Location: Assembly SUMMARY: Requires health care providers to report continuing education or competency courses that advance or promote patient care. Changes the requirements for renewal of a license or renewal of a license for nurses. Requires the approval of an approved provider from representing such a course as acceptable.

CA SB 615 AUTHOR: DeSaulnier (D) TITLE: Controlled Substances Reporting Intro. 02/18/2011 Last Amend: 08/27/2012 Disposition: Failed Location: Senate SUMMARY: Establishes the CURES Fund to receive funds to be allocated to the Department of Justice for the Controlled Substance Utilization Review and Evaluation System (CURES) program that provides for the electronic monitoring of the prescribed and dispensing of Schedule II, Schedule II, and Schedule IV controlled substances by all authorized prescribers. Requires increased license fees for dentists, pharmacists, nurses, veterinarians, nurses, osteopaths, optometrists and pilots if funding is insufficient.
STATUS: 08/29/2012 In ASSEMBLY Committee on BUSINESS, PROFESSIONS & CONSUMER PROTECTION; Failing.
Start YOUR STORY Today!

California State University San Marcos (CSUSM) is now accepting applications for healthcare degree and training programs online and at its San Marcos/North San Diego and Temecula campuses. These programs are specifically designed for the working adult wanting to finish their studies “on-time” and “on-budget.” Programs include:

- Accelerated Bachelor of Science in Nursing
- RN to Bachelor of Science in Nursing
- Nurse Refresher
- Master of Science in Nursing
- Master of Public Health
- Healthcare Information Technology certificate
- RN to Master of Science in Nursing
- Medical Transcription
- Medical Billing & Coding
- Administrative Dental Assistant
- Physical Therapy Aids
- Pharmacy Technician
- Physical Therapy Aide

CSUSM healthcare programs are designed for the working professional, allowing for flexible scheduling. A cohort-based model for on-campus degree programs allows students to take required courses sequentially and together, ensuring that everyone stays on track and meets their degree goal while nurturing a strong support base and professional network. Many programs are approved for Workforce Investment Act (WIA) participants.

For more information visit www.csusm.edu/el or call 760-750-4020.
Speaking on California Nursing in Malta

by Tricia Hunter

The European Public Health Conference conducted a pre-conference for the Department of Nursing in Paris. The focus was on nurse staffing and the impact on patient care. I was invited to speak on the politics of staffing ratios, with the goal of helping French nurses develop leadership skills in the political arena. Nursing in France is a bit behind the U.S. The nursing department was moved to the University setting two years ago and is housed in the Department of Health. Every nurse gets a four year degree from the University. They are excited about the masters degree and increasing nursing research in France.

The conference was held in Malta. Malta is an island in the Mediterranean Sea, with a 7000 year history, that includes being a major battle site in World War II. Malta had been owned by the Knights of St. John until they were kicked out by Napoleon. England conquered Napoleon and Malta was a colony until 1964 when it gained its independence.

All of the speakers were fantastic:

Dr. Rafferty, Dean of Nursing Policy, Kings College London was a major contributor to the first staffing study in Europe. The greater the patient loads the higher the patient mortality. The higher staffing ratios have saved 2000 lives annually. Twelve countries in Europe, two in Africa, the United States plus provinces in China participated in the study. The study showed there are lots of room for improvement. She shared a number of slides about nursing assessment of patient care loads, job satisfaction, and fear of reporting problems. She stated the INH may not mean the highest pay in a country to try and this needed to be explored. The content of the degree is as important as the degree and this needs to be reviewed.

Walter Semeus, Katholieke University of Belgium, is a lead researcher for the RN4Cast study for nursing. France, Italy, and Portugal are interested in repeating the study. The World Health Organization (WHO) Europe is looking at ethical recruiting around the world and its impact on staffing.

Magnet Status: Dr. Rafferty discussed need for magnet in Europe. They are looking at modifying the system for other countries to use. Linda Atkins is working with Russian satellite countries on staffing and magnet issues. She stated nursing must be involved with decision making of patient care. Setting thresholds does not blow issues. She stated the nurse was the constant. She spoke of a personal incident with her family. Much of this discussion remained to me of the nursing battles 10 to 20 years ago in America.

The European President of Nursing Directors talked about the expectations of the patient that the nurse was competent, but it was the emotional side they cared about. Her presentation was on the process of statute and regulations in the U.S. and California. She also shared the history of staffing ratios in our state. The group was fascinated that a nurse had run for office and had questions about developing nursing leadership.

David Benton, CEO of ICN, presented after me about nursing organizations role in patient and nurses advocacy. He talked about issues such as not having adequate safety supplies in some countries, technology impacts, and staffing. He stated we need to optimize what nurses do. He talked about advocacy by nursing organizations. A coalition of nursing leaders are taking on the issue of fake medication through the WHO.

Roselyn Gasser, Director at Paris hospital, shared that they only have ratios in specialties, ICU, and pediatrics. She described the dilemma of getting nurses involved. Christophe Debout and Odessa Daniel spoke about the missing link in France leadership. There are 500,000 nurses in France. Christophe stated that in France the nursing voice has been lost. Nursing does not have a vision for itself. Only 11 percent are registered even though it is mandatory. A Chief Nursing Director does not exist. Two nurses are in parliament, 31 doctors. The word leadership does not translate to French and I learned the word leadership is not used in Germany because it implies Hitler. Most nurses do not speak. English so this is a barrier to the literature on leadership in nursing. I learned that most of the nursing research and other literature on nursing is out of the U.S. and therefore in English.

The final speaker was Jacqueline Filkins, independent advisor with the EU on nursing leadership and education and Honorary President of the Nurse Directors Association. She addressed ethical dilemmas with staffing and a recession. She helped develop an ethical statement for Nurse Directors in Europe.

This was my first international meeting. I found the differences interesting and the common themes fascinating. I enjoyed meeting and speaking with nurses and hospital administrators from France, England, Belgium, Malta, and Austria.
Single-Use Vials: Safety, Cost, and Availability

Medscape, Aug, 02, 2012

Reusing Healthcare

The problem of reuse of single-use medical items and devices is not new. Almost as soon as healthcare began adopting single-use and disposable items in the 1970s for purposes of infection control, the reuse of such items began as a cost-saving measure. Despite infection control guidance to the contrary, in 2008, 20%-30% of US hospitals reported that they reused at least 1 type of single-use device.1

Evidence suggests that reuse practices extend to sterile items of variable drugs intended for one-time use. For example, some nurses and other healthcare providers admit to practices such as re-entering single-dose/single-use sterile vials after the initial access, either for the same or different patients, or inappropriately diluting contents of single-dose vials. A 2012 online survey2 of 5446 healthcare practitioners found that 6% of respondents sometimes or always used single-dose/single-use vials for multiple patients, 15% used the same syringe to enter multidose vials, and 9% sometimes or always used a common bag or bottle of intravenous solution as a source of flushes and drug diluents for multiple patients. Comments made by respondents suggest that healthcare practitioners have many misconceptions about infection safety with single-use vials.

Why would educated healthcare professionals, committed to patient safety, do such a thing? The reasons are many. Efficiency, time constraints, conservation of resources, avoidance of waste, and cost considerations have all been cited to rationalize the misuse of single-dose vials. Of significance, however, most healthcare professionals who regularly use single-use vials inappropriately don’t fully realize how dangerous it is to do so. If aseptic technique is maintained, they reason, what’s the problem?

The Single-Use/Dose Vial

According to the Institute for Safe Medication Practices (ISMP), “single-use or single-dose vials should be used clinically only for one dose for one patient, and then discarded after initial entry into the vial.”3 Vials intended for single use are labeled “single use/ single dose” for a very good reason. These vials contain no preservative or antimicrobial to prevent bacterial contamination. Because such contamination is not visible to the human eye, it must be assumed that once the stopper is penetrated or the ampule is broken, contamination may have occurred despite our best intentions, posing a risk for serious infection to the patient who next receives contents withdrawn from the vial.

The Risk Is Real

If a healthcare provider breaks infection control technique when preparing and giving a sterile injection (forgets to wash hands, fails to prepare the skin, accidentally touches the needle, etc.) the risk of introducing infection to that patient rises. This risk has always been present and probably happens more than we realize. Still, we hope that when this happens, only that patient will suffer the consequences of our lapse in proper technique. When a healthcare provider inadvertently contaminates a single-use vial and reuses that vial for more than one patient, it is not only a single infection that can occur, but an outbreak.

Two outbreaks of serious invasive staphylococcal infection were recently determined to be caused by the use of single-dose vials for more than 1 patient.6 The first outbreak occurred in a hospital where maintenance of aseptic technique was not followed, but an outbreak. A 2012 online survey of 5446 healthcare practitioners found that 6% of respondents sometimes or always used single-dose/single-use vials for multiple patients, 15% used the same syringe to enter multidose vials, and 9% sometimes or always used a common bag or bottle of intravenous solution as a source of flushes and drug diluents for multiple patients.

The second outbreak occurred in a hospital-affiliated orthopedic clinic. Staff members entered single-dose vials of injectable drugs intended for one-time use. For epidural steroid injections or nerve-block procedures, the anesthetic bupivacaine for use in joint injection procedures for multiple patients from 30-ml single-dose vials until the vial contents were depleted. Within days of their procedures, 7 patients required hospitalization, with sepsis and mediastinitis, bacterial meningitis, epidural abscess, and sepsis with methicillin-resistant Staphylococcus aureus (MRSA) and required hospitalization.

What did these healthcare professionals do, or not do, that transmitted MRSA to these patients? Although the primary lapse in injection safety technique was determined to be the reusing of a single-dose vial for multiple patients, the investigation also found that staff were not wearing facemasks during spinal injection procedures.

The second outbreak occurred in a hospital-affiliated orthopedic clinic. Staff members entered single-dose vials of injectable drugs intended for one-time use. For epidural steroid injections or nerve-block procedures, the anesthetic bupivacaine for use in joint injection procedures for multiple patients from 30-ml single-dose vials until the vial contents were depleted. Within days of their procedures, 7 patients required hospitalization, with sepsis and mediastinitis, bacterial meningitis, epidural abscess, and sepsis with methicillin-resistant Staphylococcus aureus (MRSA) and required hospitalization.

Proving the Why

Investigations into these 2 outbreaks aimed to determine why staff members used single-dose vials for multiple patients in violation of vial labeling. In the first outbreak, the rationale was the lack of an appropriately sized single-dose vial of contrast agent for patient need. A single 10-ml vial contained more than enough volume for 1 patient and, in fact, was sufficient for 6 or more patients. Drawing only a fraction of the vial contents for a single patient and discarding the remainder seemed unnecessarily wasteful. However, in this case, a smaller-volume single-dose vial was not available.

The national drug shortage was a factor in the unsafe injection practices of the outbreak involving bupivacaine. To conserve resources, staff used each 30-ml vial of anesthetic, as needed, for multiple patients, until the vial contents were depleted. If the 30-ml vial was not used in a single day, the vial was not discarded but saved for use the following day.

Centers for Disease Control and Prevention (CDC) Medical Officer Melissa Schaefer, MD, reflects on the reasons that staff in these 2 healthcare settings employed the unsafe injection practice of reusing single-dose vials for more than 1 patient. “One issue appeared to be access to an appropriate-size vial for clinical use, either because of the national drug shortage or because the manufacturer does not make that vial size. However, providers need to be reminded that difficulty in getting the vial size you feel is most appropriate is not an excuse to deviate from safe technique.”

One and Only One

CDC’s position on the use of single-dose vials is simple, straightforward, and unequivocal: Single-dose vials should be dedicated to an individual patient as part of an individual procedure. Any contents not used for that patient should be discarded. Contents should not be transferred from single-dose vials should neither be used for additional patients nor stored for future use in the same patient. There is a very good reason for this: Single-dose vials contain no preservative agent to prevent bacterial growth that might be introduced upon vial entry. Once entered, the contents of these vials can support the growth of micro-organisms, with subsequent transmission to the same or multiple patients.

This policy is not new. Originally detailed in CDC’s 2007 safe injection practice guidelines,7 the policy was

---

ANAAC The Nursing Voice • Page 11

Single-Use Vials continued on page 12

The Nursing Voice is a publication section of the American Nurses Association (ANA) and is distributed to all members of the ANA. The Nursing Voice is not peer reviewed.
...when using single-use vials in patient care.

It is possible that, in a fast-paced healthcare environment, some healthcare providers are unaware of or forget the differences between single-dose and multidose vials, particularly if labels are not read carefully. The primary difference is the presence of an antimicrobial substance to minimize risk for bacterial contamination. Even multidose vials that contain preservatives, however, have been implicated in infectious outbreaks with transmission of both bacterial and viral infections. Dr. Schaefer emphasizes that “Providers shouldn’t rely on a preservative as a safety net for lapses in aseptic technique.” The fact that some single-dose vials seem to contain more volume than may be required for a single patient use could be contributing to confusion about appropriate vial use. The volume of solution in the vial does not determine whether the vial is single-dose or multidose. CDC clarifies that even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than 1 patient or stored for future use in the same patient.

To prevent unnecessary waste or the temptation to use contents from single-dose or single-use vials for more than 1 patient, clinicians and purchasing personnel should select the smallest vial size necessary for an individual patient when making treatment and purchasing decisions. If desired vial sizes are not currently available, Dr. Schaefer encourages healthcare providers and pharmacies to communicate their needs directly to manufacturers and indicate that there is a market for smaller vials and prefilled syringes for single-dose or single-use vials must be divided, there are options to minimize patient risk.

Using a High-Quality Pharmacy

CDC recognizes that the issues that prompt healthcare providers to deviate from safe practice are real and unlikely to be resolved overnight. Although it is optimal for a medication vial to be used for only 1 patient, shortages of critical medications may justify the splitting and repackaging of vial contents under strictly controlled conditions. CDC’s position on single-use vials extends the option of having the contents of a single-dose vial subdivided and repackaged into multiple single-use syringes or vials by high-quality pharmacies or pharmacy outsourcing that adhere to US Pharmacopeia (USP) 797 standards for sterile preparation and storage. From single-dose or single-use vials for more than 1 patient or stored for future use in the same patient, that vial should not be used for more than 1 patient or stored for future use in the same patient.

To prevent unnecessary waste or the temptation to use contents from single-dose or single-use vials for more than 1 patient, clinicians and purchasing personnel should select the smallest vial size necessary for an individual patient when making treatment and purchasing decisions. If desired vial sizes are not currently available, Dr. Schaefer encourages healthcare providers and pharmacies to communicate their needs directly to manufacturers and indicate that there is a market for smaller vials and prefilled syringes for single-dose or single-use vials must be divided, there are options to minimize patient risk.

Using a High-Quality Pharmacy

CDC recognizes that the issues that prompt healthcare providers to deviate from safe practice are real and unlikely to be resolved overnight. Although it is optimal for a medication vial to be used for only 1 patient, shortages of critical medications may justify the splitting and repackaging of vial contents under strictly controlled conditions. CDC’s position on single-use vials extends the option of having the contents of a single-dose vial subdivided and repackaged into multiple single-use syringes or vials by high-quality pharmacies or pharmacy outsourcing that adhere to US Pharmacopeia (USP) 797 standards for sterile preparation and storage. From single-dose or single-use vials must be divided, there are options to minimize patient risk.

Using a High-Quality Pharmacy

CDC recognizes that the issues that prompt healthcare providers to deviate from safe practice are real and unlikely to be resolved overnight. Although it is optimal for a medication vial to be used for only 1 patient, shortages of critical medications may justify the splitting and repackaging of vial contents under strictly controlled conditions. CDC’s position on single-use vials extends the option of having the contents of a single-dose vial subdivided and repackaged into multiple single-use syringes or vials by high-quality pharmacies or pharmacy outsourcing that adhere to US Pharmacopeia (USP) 797 standards for sterile preparation and storage. From single-dose or single-use vials must be divided, there are options to minimize patient risk.

Using a High-Quality Pharmacy

CDC recognizes that the issues that prompt healthcare providers to deviate from safe practice are real and unlikely to be resolved overnight. Although it is optimal for a medication vial to be used for only 1 patient, shortages of critical medications may justify the splitting and repackaging of vial contents under strictly controlled conditions. CDC’s position on single-use vials extends the option of having the contents of a single-dose vial subdivided and repackaged into multiple single-use syringes or vials by high-quality pharmacies or pharmacy outsourcing that adhere to US Pharmacopeia (USP) 797 standards for sterile preparation and storage. From single-dose or single-use vials must be divided, there are options to minimize patient risk.

Using a High-Quality Pharmacy

CDC recognizes that the issues that prompt healthcare providers to deviate from safe practice are real and unlikely to be resolved overnight. Although it is optimal for a medication vial to be used for only 1 patient, shortages of critical medications may justify the splitting and repackaging of vial contents under strictly controlled conditions. CDC’s position on single-use vials extends the option of having the contents of a single-dose vial subdivided and repackaged into multiple single-use syringes or vials by high-quality pharmacies or pharmacy outsourcing that adhere to US Pharmacopeia (USP) 797 standards for sterile preparation and storage. From single-dose or single-use vials must be divided, there are options to minimize patient risk.
injection outcomes. At the same time, changes to community practice can only occur when appropriately sized and reasonably priced single-dose vials of commonly used medications become widely available,” explains Dr. Baker. ISISS has been working with CDC, other professional organizations, and manufacturers to provide healthcare professionals with safe and cost-effective single-dose contrast media alternatives. The organization also encourages its members to review and improve their injection safety practices as outlined by CDC, but Dr. Baker acknowledges that “rapid implementation may not be feasible for some providers. It is our concern that, unless the issues of availability and appropriately priced single-dose vials are addressed, drug shortages could occur, along with a reduction in the number of providers who would be able to continue to perform these procedures. This could create access-to-care issues for these patients who, by the very nature of their problems, are suffering greatly already.” On its Website, in a message from Dr. Baker, ISIS explains its current position on the use of single-dose vials in interventional pain management.

The American Society of Anesthesiologists (ASA), in a statement on its Website, says, “ASA supports CDC’s position and adopted CDC’s Safe Injection Practices.”

Expressions of support have also come from the professional pharmacist community. ASHP supports CDC’s position on use of single-dose vials and endorses USP 797 requirements for preparation of sterile compounds. “In spite of increased cost, the risk of using single-dose vials is unacceptable to health professionals,” says Eon E. Benjamin, BS Pharm, Director, Medication-Use Quality Improvement and Coordinator of the Drug Shortages Resource Center for the ASHP. Benjamin acknowledges that “healthcare providers face an extremely challenging dilemma when they must discard single-dose vials of expensive or hard-to-obtain injectable medications, especially when there is a possibility of a negative outcome for their patients.”

ASHP believes that this strong disincentive to compliance should not be underestimated. The healthcare community should be made aware that there are several options to counter it. One is a provision in the new US Food and Drug Administration (FDA) Safety and Innovation Act that allows health systems to centralize much of their sterile product compounding for their member hospitals in a single USP-compliant, system-owned facility. Another option is to request manufacturers to add more unit-of-use, single-dose injectables to their product lines or contract for unit-of-use products with an outsourcer. When using larger-volume, single-dose vials is unavoidable, they urge manufacturers of these products to develop containers for them that cannot be reused once opened.

The American Pharmacists Association “encourages pharmacists and other health professionals to follow established CDC and FDA guidelines and to maintain open communication among all stakeholder groups to best meet the needs of their communities.” The ISMP also concurs with the positions of both CDC and CMS on the reuse of single-dose vials. ISMP Executive Vice President Allen J. Vaida, PharmD, states that since the 1970s, the ISMP has been reporting on infections that have occurred following the inappropriate use of single-dose vials.

The Bottom Line: Patient Safety

In response to concerns that single-use vials could contribute to drug shortages and increase costs to healthcare providers, CDC points to an FDA report indicating that drug shortages are a result of manufacturing, shipping, and other issues unrelated to the guidelines. The imperative to protect patients from harm resulting from the actions of healthcare professionals is foremost. The serious nature, and resulting expense and patient impact, of an outbreak cannot be ignored in this equation. Drug shortages, availability, and waste are issues that must be dealt with through appropriate channels and without endangering patients.

References

The IOM standing committee will maintain surveillance of the field, discuss planning and program development efforts, and serve as a focal point for discussions and potential ad hoc workshops and future studies by IOM committees include:

- emerging priorities for nursing credentialing research
- research methodologies and measures relevant to nursing credentialing research and outcomes assessment
- the impact of individual and organizational credentialing in nursing on improving healthcare quality
- strategic planning for moving the field of nursing credentialing research forward

"Nurses play a crucial role in health care. As the scope and intensity of nursing responsibilities grow, thoughtful reflection and planning for research on the credentialing of nurses will be increasingly important. We hope the new Standing Committee on Credentialing Research in Nursing will help meet this need," said Harvey V. Fineberg, MD, PhD, president, Institute of Medicine.

"This is a huge step forward for nursing research. We are very pleased that the IOM has committed resources to support this work, including participating in the SPARC program," said ANCC President Michael Evans, PhD, RN, NEA-BC, FAAN.

For more information and to sign up for notices about the committee’s activities, please visit www.iom.edu/Activities/Workforce/NursingCredentialing.

About ANCC
The mission of the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), is to promote excellence in nursing and health care globally through credentialing programs. The ANCC’s internationally renowned credentialing programs certify and recognize nurses in specialty practice areas. It recognizes healthcare organizations that promote nursing excellence and quality patient outcomes, while providing safe, positive work environments. In addition, ANCC accredits healthcare organizations that provide and approve continuing nursing education. It also offers educational materials to support nurses and organizations as they work toward their credentials. The ANCC is the first and only healthcare certification organization in the United States to have successfully achieved ISO 9001:2008 certification. For more information, visit www.nursecredentialing.org.

American Nurses Advocacy Institute
by Melanie Krupa, RN, MN

The American Nurses Association (ANA) held its fourth annual American Nurses Advocacy Institute (ANAI) on September 30th - October 2nd in Washington D.C. I was among nineteen nurses that participated from fourteen states. This is a yearlong mentored program that is designed to develop political leadership skills for growing a cadre of nurses. The skills learned from ANAI will prepare and assist nurses in having the information, facts, and knowledge in order to have a positive impact on policy decisions at the state, local, and national level.

Sessions were held on navigating the legislative process. The topics that were covered were how to conduct a political environmental scan, how a bill doesn’t become a law, and messaging for different audiences. Minnesota State Representative, Erin Murphy, RN, BSN, MA was the guest speaker who spoke about creating and crafting messages through a politics.

She was elected in 2006 and is currently serving her 3rd term. Healthcare policy and delivery systems has become a political spotlight in Washington D.C. and among individual states. Governmental health care decisions are frequently made by legislators and lawmakers who are not health care professionals. It is encouraging to know that Erin Murphy is a health care professional who uses her experience and expertise in making vital decisions that are based on the needs of health care.

The nursing profession represents the largest number of health care providers in the United States. Nurses that are elected to an office have the opportunity to effectively promote health care policy. Representation at this level ensures that nurses have a voice on issues that affect safe practice, staffing ratios, health care reform, violence against nurses, and continuing education opportunities. It is important that the nursing profession define its own standard of care, one that is not defined by others. As nurses, it’s imperative that we stay informed about health care issues at the state and federal level. Information-gathering is a powerful tool and a critical step in the participation process of policy development.

There are many ways that nurses can become politically active and influence the future of nursing. The easiest way is to become a member of your state nursing association or a specialty organization. (Contact information can be found at www.anacalifornia.org) Attend debates or town hall meetings and reach out to your state and local representatives. Let your voice be known. Voting is the number one way to be heard and people look to you for your opinions. Volunteer your time to a campaign or to a cause that you feel passionate about. Become a registered voter and give your voice the validity it deserves. Now is the perfect time for nurses to learn the political process to ensure safe, efficient, and effective health care policies within America’s health care system.

Should you be interested in participating in a future program, please contact ANAC to seek endorsement. Grassroots experience and demonstrated commitment to support of the association is required for consideration. The program is highly competitive and limited to no more than 24 participants per year. Questions may be directed to Janet Haebler MSN, RN, Associate Director, ANA State Government Affairs at janet.haebler@ana.org.
“California Casualty’s rates are the best.”

“I checked out the rates from all the different companies. California Casualty was the best, so I switched. I’ve been happy ever since.”

Get your no-obligation quote for auto & home insurance.

1-866-655-0705
www.CalCas.com/NURSES

EXCLUSIVE BENEFITS FOR REGISTERED NURSES LIKE YOU

- Special Rates/Generous Discounts
- Up to $500 Deductible Waiver*
- Convenient Payment Options
- ID Defense — Free

* Not available in GA, NH or TN
Heart disease prevention starts with me. Prevention can start with you, too. Scan this QR code to watch videos and read stories about Kim, and other everyday champions in CVD prevention.

www.pcna.net/preventioninCA

Kim Newlin, RN, CNS, NP-C, FPCNA is a cardiovascular clinical nurse specialist and primary care adult nurse practitioner at Sutter Roseville Medical Center in Roseville, California. She is an advocate for prevention, health literacy and being a healthy role model for her patients. All around the world, nurses are catalysts for heart disease prevention in their clinics, hospitals and communities.