Nursing is often described as a science and an art, requiring an understanding of everything from cellular function to family dynamics. It’s also a profession that is rife with challenges and opportunities, many of which are fueled by nurses’ own imaginations and the influence of their colleagues.

With National Nurses Week celebrations all but wrapped up, here’s a brief look at four more nurses who each have different roles, but whose efforts are aimed at improving the lives of patients and colleagues.

**Linda Aiken, nurse researcher & change agent**

Linda Aiken read a lot as a child: the nurse-focused Cherry Ames series, the physician-centered works of Frank Slaughter, MD, and the microbial-inspired book on antiseptic advocate Ignaz Semmelweis.

“All those stories captured my imagination,” said Aiken, PhD, RN, FAAN, FRCN, director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing and Pennsylvania State Nurses Association member. They — and her geographic locale — also pointed her toward a career in nursing.

“I grew up in the shadow of the University of Florida (UF) at Gainesville, which I thought was the greatest place in the world,” Aiken said. “And there was a nursing school there.”

After graduating in 1964, she, like many new staff nurses, went straight to working the night shift.

“I loved nursing and the unit, but it was evident to me right from the start that there were many things wrong with the clinical environment, things

See **Influential reach** on page 7

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**Fleeting or pandemic?**

RNs draw on experience, planning to respond to current influenza outbreak

By Susan Trossman, RN

With comparisons made to both the Spanish flu and the avian flu, the recent emergence of H1N1 influenza set nurses in motion nationwide to contain a potential pandemic. Their response, from inside school buildings to emergency departments to public health centers, has shown just how crucial nurses are to ensuring the nation’s health.

The Spanish flu killed as many as 50 million people worldwide between 1918 and 1920, while the avian flu has resulted in 257 deaths since 2003. In terms of the current outbreak the World Health Organization (WHO), as of May 20, reported 10,243 confirmed cases of H1N1 — initially referred to as swine flu — in 41 countries and 80 deaths, at press time.

“For nearly a decade ANA has encouraged nurses to prepare themselves both professionally and personally in the event of a pandemic or other disaster,” said Katie Brewer, MSN, RN, senior policy analyst in ANA’s Department of Nursing Practice and Policy. “We particularly have emphasized the importance of all nurses knowing what their specific role is in their facility’s disaster response plan — whether it’s in a hospital, a public health department, or an ambulatory care center.”

ANA also has urged nurses to work with administrators if their facility has no disaster response plan, get their annual flu vaccination, and sign up well in advance for disaster response registries, such as the Medical Reserve Corps, if they want to play a more active role in major events.

Since the onset of the H1N1 outbreak, ANA has posted information on its Web site (www.nursingworld.org), including important links to Centers for Disease Control and Prevention (CDC) resources. Brewer noted that many

See **Fleeting or pandemic?** on page 6
### Benefits

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<th>proliability.com</th>
<th>Employer-Sponsored Plan¹</th>
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<td>Offers up to $2M/$4M individual limits</td>
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<td>Covers volunteer and part-time work</td>
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<td>Provides you with your own attorney if you are named in a malpractice lawsuit</td>
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<td>Reimbursement for lost earnings while attending a trial, hearing or arbitration proceeding at the request of Chicago Insurance Company</td>
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<td>Pays covered court costs and settlements in addition to liability limits</td>
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<td>Allows you to take your coverage with you if you leave your employer (Portability)</td>
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### If you were named in a medical malpractice lawsuit today, would your employer-sponsored liability coverage protect your best interests?

Probably not. In fact, it's likely that your workplace plan is meant to serve as a group policy that covers all employees mentioned in a lawsuit with limits that put your best interests at risk.

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Get a no-obligation quote and apply for instant proof of coverage.² Visit [www.proliability.com/42252](http://www.proliability.com/42252) or call 1-800-503-9230 to speak with a professional liability representative today.

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² Pending underwriting approval
We put safety first

You do not have to be a rocket scientist to understand that certain aspects of our jobs as nurses are unsafe, and not just to us but also to our patients.

Nursing is a physically demanding job, and despite our best intentions, at times we are put in situations that have a high risk of personal injury in the course of doing our jobs. Studies have shown that nursing personnel have the highest workers’ compensation claim rate of any occupation or industry — an alarming statistic when you consider that the list includes truck drivers, laborers, and others whose jobs involve heavy manual labor. According to figures from the Bureau of Labor Statistics, nursing aides, orderlies, and attendants ranked second, and RNs fifth, in a list of at-risk occupations for strains and sprains.

The cost of these injuries to the country is enormous — back injuries alone account for billions of dollars in lost revenue and workers’ compensation every year, and that may be a conservative estimate.

I suppose to some, it’s just money. But the human cost goes beyond any monetary value. Every year we lose thousands of nurses to injury, further contributing to the nursing shortage.

Why does our profession incur such a high injury rate? One of the biggest reasons is a lack of safe patient handling awareness.

While many nurses don’t think twice about lifting a 100-pound patient into or out of a bed or gurney, I have yet to see a worker in Home Depot or Lowes lift a heavy item, such as a 100-pound bag of cement, by hand. These workplaces have rules against such practices to protect their workers and avoid the costs associated with on-the-job injuries from manual lifting. That this type of manual lifting is accepted as normal in the health care setting is downright wrong, no matter how it is the only acceptable way. Let’s not settle for anything less.

It is the only acceptable way. Let’s not settle for anything less. This is why I believe ANA’s newest recognition program will help motivate and provide additional incentives to change our current unsafe practices and behaviors and will ultimately eliminate manual handling nationally. Announced this spring, the ANA Handle With Care Recognition Program® will recognize health care organizations that have achieved a comprehensive safe patient handling program that meets ANA established criteria. This program offers many benefits to health care organizations, to nurses, and to patients.

Health care organizations that earn the program’s recognition will benefit by enhancing their standing as an employer of choice. All things being equal, wouldn’t you rather work for a hospital that has earned this recognition for safeguarding its nurses and patients? Nurses will benefit from the program in that they will be provided with the tools and knowledge to help avoid disabling and potentially career ending musculoskeletal injuries. Finally, patients will benefit because they will enjoy a safer level of care during their time receiving health care. Everyone wins.

The ANA Handle With Care Recognition Program will become the gold standard for safe patient handling programs. There are a growing number of hospitals with great programs for safe patient handling that show us how it can be done, and give us the models for doing so. They deserve to be recognized for their leadership in eliminating manual lifting and making the work environment safer for both patients and staff.

For the safety and good of the patient, nurse, and health care as a whole, this is not only the better way, it is the only acceptable way. Let’s not settle for anything less.

Studies have shown that nursing personnel have the highest workers’ compensation claim rate of any occupation or industry — an alarming statistic.
**Weston to join ANA as CEO**

On June 14 ANA welcomes its new chief executive officer (CEO), Marla J. Weston, PhD, RN. Weston, who will also serve as the CEO of the American Nurses Foundation, comes to ANA from the U.S. Department of Veteran Affairs, where she held the position of deputy chief officer. Among other experiences in her nearly 30-year career in nursing management, she was the executive director of the Arizona Nurses Association and, as such, brings considerable experience in managing a nursing organization to her new role at ANA.

“This is a huge honor to be selected by the [ANA] board of directors to serve in this position,” Weston said. “I am very humbled by and present to the obligation and am 100 percent committed to serving our members and the nurses of the United States.”

Weston feels that the country is entering an exciting time in terms of health care reform, and she believes that ANA will have a significant role to play in that discussion.

“Our country is ready to have a conversation on health care reform,” she said. “Nursing has been ready for a long time to have that conversation. This is a golden moment for ANA and for nursing to really be known for and then communicate that relevance to every nurse in the United States.”

Weston said that one of the more pressing challenges for ANA as an organization is to focus more clearly on its priorities so it can better communicate what ANA does for the profession and the tangible benefits of membership to all nurses nationwide, not just to ANA members. “ANA is doing an enormous amount of relevant work for RNs in the United States,” she said. “We need to strategically determine what we most want to be known for and then communicate that relevance to every nurse in the United States, so that they really understand exactly what we’re doing and want to support those efforts through an ANA membership.”

Weston relates that this notion of bringing ANA’s activities to the attention of all U.S. nurses was one of the things that attracted her to the job at ANA. “I have been an ANA member for a long time and had been the executive director for a constituent member association (CMA), so I’m very clear about what ANA does for the profession and the tangible benefits of membership to all nurses,” she said.

She also believes that ANA needs to find better ways to work with other nursing organizations to maximize our collective impact. “We are strongest when ANA is a strong partner with the CMAs and when ANA is a strong partner with other nursing organizations,” Weston said. “We have an opportunity to strengthen our partnerships, to work together, to really leverage our strengths. I think we have big opportunities there.”

Weston said that although she has come to see nursing as a perfect fit for her life’s mission, she was not always ready to embrace the profession. “My mother was a nurse, so I was pretty much going to be anything other than a nurse [laughs]. After high school, I had this ‘aha’ moment in which I realized that all of the things that I loved and all of the things that I thought were important were things that perfectly fit with being a nurse,” Weston said. “Things that had to do with making a difference in peoples’ lives; serving people in a way that helped them — that’s really what nursing is all about. So it was what I was always meant to do.”

Weston replaces former CEO Linda J. Stierle, MSN, RN, CNA, BC, who retired May 5. ANA General Counsel Alice L. Bodley, Esq., is serving as interim CEO until June 14.

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**In Brief**

**Hail to the chief’s health reform office**

ANA applauds President Obama’s executive order to establish a White House Office of Health Reform as a positive step toward achieving one of ANA’s top priorities: guaranteeing ready access to affordable, high-quality health care services for all people in the United States.

“ANA looks forward to working with the Obama Administration and the White House Office of Health Reform to help make universal access to essential health care services a reality,” said ANA President Rebecca M. Patton, MSN, RN, CNOR. “As a grassroots organization, ANA appreciates that the Office of Health Reform is charged with working with state, local, and community policymakers. That should give nurses on the frontlines more opportunities to make their concerns, experiences, and knowledge heard.”

ANA has long advocated that health care is a basic human right and contends that the current fragmented and costly U.S. health care system is in a state of crisis that patchwork approaches will be inadequate to fix. ANA emphasizes that ensuring an adequate nursing workforce is an essential component of meaningful health care reform to truly provide access to care for all.

**Measuring collaboration**

The American Organization of Nurse Executives (AONE) released a new benchmarking survey tool that provides hospitals with the opportunity to quantify nursing satisfaction with support services to build a more collaborative work environment.

The Nursing Satisfaction with Support Services (NS3) survey tool is now available for hospitals to use to determine strengths and areas for improvement.

The survey tool will be useful for hospitals that want to positively impact patient care, build a more collaborative work environment, assimilate new nursing or support service leadership, pursue Magnet® status, or establish baselines to measure future performance and set improvement targets, according to AONE. Participating hospitals will receive customized reports that can be compared against a provided national benchmark report. Individual satisfaction reports will be provided for eight support service areas: food and nutrition, environmental services, facility maintenance, clinical engineering, laundry and linen, security, central supply, and patient transport.

To establish national benchmark data for this survey, ARAMARK Healthcare, which assisted in the development of the NS3 survey tool, distributed the survey online to nearly 40,000 nurses during the spring and summer of 2008. A total of 7,472 nurses from 65 hospitals across the United States, as well as several Canadian facilities, participated in the study, representing a 19 percent response rate.

“The launch of this survey is a strong continuation of the work that began with the development of the AONE Guiding Principles for Relationships among Nursing and Support Services in the Clinical Setting,” said Pamela A. Thompson, MS, RN, FAAN, chief executive officer of AONE and Virginia Nurses Association member. “Building a more collaborative relationship between nursing and support services is critical to improving the quality of care that our patients receive.”

For more information, go to www.aone.org.

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Nurse laid off during surgery

A manager at a Wisconsin clinic called a nurse out of a minor surgical procedure to notify her that she was being laid off, according to news reports.

According to Paul Pitas, a spokesperson for Dean Health System, the event was a violation of medical protocol, but it did not pose a danger to the patient.

“Out of respect for the manager we cannot discuss specifics,” said Pitas in his quotes in a Wisconsin State Journal article. “However, we can tell you we are looking into this and appropriate action will be taken.”

The layoff reportedly affected 90 of the company’s 4,500 employees.

Medicare narrows disparity gaps

Obtaining Medicare coverage is associated with significant reductions in racial, ethnic, and socioeconomic health disparities in adults with diabetes and cardiovascular disease, according to a new Commonwealth Fund-supported study in the April 20 issue of Annals of Internal Medicine.

The study, by J. Michael McWilliams and colleagues at Harvard University, points to universal coverage as a possible means of reducing these types of health disparities in the general population.

The authors reviewed health data from more than 6,000 people ages 40 to 85 with diabetes, high blood pressure, and high cholesterol. They found that while overall improvements have been made in controlling the diseases, racial, ethnic, and socioeconomic differences have remained the same or in some cases worsened in the pre-Medicare population. However, at age 65 when people become eligible for health care coverage under the Medicare program, differences in health by race, ethnicity, and socioeconomic status were reduced significantly.

Findings reveal the following:

- For systolic blood pressure, racial disparities decreased by 60 percent.
- For blood sugar levels with diabetes, educational disparities decreased by 83 percent, while racial and ethnic disparities fell by 78 percent.
- For total cholesterol levels, educational disparities disappeared altogether.

“The results of this study make it clear that guaranteeing access to affordable insurance for all Americans is the essential first step toward a high performing health care system and a healthier America,” said Commonwealth Fund President Karen Davis. “As our leaders look toward health reform it is critical that they take into account the value of health care coverage for everyone and assure that all Americans have the ability to obtain insurance for themselves and their families.”

NursingWorld revises Health System Reform section

ANA launched a revised and expanded section in May of its Web site devoted to increasing the visibility and impact of its Health System Reform campaign.

The new section can be reached by going to ANA’s home page at www.NursingWorld.org, then clicking on “Health System Reform” in the drop-down menu under the “Health Care Policy” tab on the top navigation bar.

In this section, Web site visitors can find ANA’s 2008 Health System Reform Agenda policy document, which provides nursing’s perspective on needed changes. Visitors also will see press releases in response to the most recent health reform activity, summaries on ANA’s principles and goals for health reform, updates on what ANA is doing to help bring about systemic changes, and recommendations on what nurses can do.

The section prominently notes that any reform strategies must take into account the adequacy of the nursing workforce to be successful in increasing access to health care and improving quality.

The Health System Reform section will continue to evolve as health reform legislation takes shape and ANA refines its advocacy strategies.

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AORN says ‘time out’

The Association of periOperative Registered Nurses (AORN) is promoting June 17 as National Time Out Day to emphasize the importance of surgical teams taking a time out to confirm vital patient information before beginning every invasive procedure.

Wrong-site surgery and other preventable mistakes still occur too frequently in operating rooms even though The Joint Commission requires all accredited health care facilities to practice a time out as part of its Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

To support the protocol and build greater awareness among surgical team members, AORN launched the National Time Out Day initiative in 2004. Its goal is to prevent errors by ensuring that all physicians, nurses, and surgical technologists pause before all invasive procedures so they can communicate as a group and confirm key information about the patient and procedure.

By working together we can eliminate preventable surgical errors,” said AORN President Patrick Voight, MSA, RN, CNOR. “It’s simply a time out with every patient, every day.”

This year, AORN collaborated with ANA, the American Association for Accreditation of Ambulatory Surgical Facilities, the Council on Surgical & Perioperative Safety, and The Joint Commission to create a poster to remind professionals, health care providers, and administrators that “Every Day is Time Out Day.”

“As nurses, we always are looking for strategies that will keep our patients out of harm’s way,” said ANA President Rebecca M. Patton, MSN, RN, CNOR. “National Time Out Day is an excellent reminder to surgical nurses, anesthesiologists, surgeons, and all surgical staff members to focus on the safety of each and every patient they see. And ANA is proud to take part in this initiative.”

As part of this patient safety initiative, AORN revised its Correct Site Surgical Tool Kit and developed a contest for members who want to showcase their facilities’ and surgical teams’ time-out procedures.

Members can get more information or download a poster from the AORN Web site at www.aorn.org/NationalTimeOutDay.
Fleeting or pandemic?  
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nurses have sought out information from the ANA site.

“Nurses have done a really good job of educating themselves on H1N1 so they can provide reliable, accurate information to their patient populations, family, and friends,” Brewer said. “And they also have engaged in a range of efforts at their worksites in case a long-term response is needed.”

Two major resources for nurses beyond the H1N1 outbreak are the groundbreaking white paper, “Adapting Standards of Care under Extreme Conditions: Guidance for professionals during disasters, pandemics and other extreme emergencies,” which was crafted at ANA’s 2007 major policy conference; and the May 2009 Online Journal of Issues in Nursing (OJIN) article, “Exploring the Concept of Surge Capacity,” by Lavonne M. Adams, PhD, RN, CCRN. It can be found at www.nursingworld.org/OJIN/No2May09/SurgeCapacity.

School, ED nurses’ response crucial

One work setting where nurses’ critical role was clearly evident during this most recent outbreak was in the nation’s schools. In an April 28 article in The New York Times, school nurse Mary Pappas, RN, was credited for uncovering the first H1N1 cluster in New York State.

“School nurses are the like the canary in the infectious disease mine,” said Martha Bergren, DNS, RN, NCSB, director of research at the National Association of School Nurses (NASN). “Diseases often crop up in kids first. So when you see 75 kids in a high school coming to your office, you know something is up.”

Bergren explained that public health surveillance is a long-standing part of the school nurse role, and school nurses routinely communicate with public health departments whenever they have outbreaks of pertussis, MRSA, or other infectious diseases.

School nurses generally receive training in identifying and handling potential epidemics through workplace orientation, and in some states through additional certification coursework. NASN also has materials and educational workshops for school nurses on disaster preparedness, and the association has advocated for school-based immunization clinics to help prevent outbreaks of flu and childhood diseases.

Prior to the CDC declaring a public health emergency, NASN sent e-mails to members and posted information on its Web site about the H1N1 outbreak. The association subsequently continued its educational efforts by providing school nurses with specific guidelines for school closures and other viral updates.

“This outbreak shows why it’s so important to have school nurses, yet 25 percent of schools in the United States don’t have one,” Bergren said. On May 5, 726 schools were closed nationwide because of the outbreak.

Nurses working in many emergency departments (EDs) also were on high alert, as patients flocked to hospitals fearing they may have contracted H1N1 influenza.

“We’ve had many people come to the ED to get checked,” said Emergency Nurses Association (ENA) President Bill Briggs, MSN, RN, CEN, FAEN, of his Boston facility. He said that emergency nurses typically see patients with seasonal influenza every year, so they are prepared to care for this patient population.

“We generally isolate them [suspected flu cases] in private rooms right away,” Briggs said. “But when there are too many people coming in, we provide them with face masks to use while they wait.”

In terms of preparing for a severe pandemic, Briggs said that ED nurses participate in annual disaster response training as part of a hospital accreditation requirement issued by The Joint Commission. Nurses specifically learn what they need to know to set up the hospital’s disaster response system, which is flexible enough to handle a range of adverse events.

However having adequate staff, hospital beds, equipment, and medication in the event of a severe pandemic is a real concern, according to Briggs.

“All of us wait in dread for when there is a major pandemic like the one in 1918,” he said. “It’s a huge possibility.” As for the latest outbreak, Briggs said that when dealing with a new virus, health care professionals don’t know what to make of it initially.

“But if you’re going to stop an outbreak, you need to act aggressively at the onset,” Briggs said. “That’s good public health planning.”

Public health challenges

ANA/California member Rosie Vasquez, RN, PHN, recently found herself part of a team of public health nurses answering calls mainly from physicians and clinic staff about H1N1 reporting protocols.

But she said that public health nurses play a larger role in promoting flu vaccination, identifying outbreaks, and educating other health care staff and the community about pandemic and seasonal flu—particularly on strategies to prevent the spread of disease.

“For the community, we focus on the importance of people covering their coughs and sneezes, washing their hands, avoiding contact with others if they have a fever, and getting adequate sleep and hydration,” Vasquez said. “For clinicians, we emphasize the importance of getting a good health history of their patients, including recent travel, and staying updated on flu protocols.”

Vasquez said that, particularly since the emergence of avian flu, health care systems and public health departments have prepared themselves for pandemics by having disaster plans in place and implementing staff drills.

But other nurses expressed concern about health care professionals’ ability to stave off epidemics or pandemics.

“The recent H1N1 outbreak reinforces my strong belief that we need to rebuild our public health infrastructure at the national and state levels,” said Christine Saltzberg, PhD, APRN,BC, chair of the New York State Nurses Association’s public health focus group and a professor in public health nursing. “Our infrastructure has steadily eroded over time as the focus has been more on care and cure rather than on health promotion, disease prevention, and education.”

Saltzberg also is convinced that all nurses must take a public health nursing course exposing them to the principles and practices of public health and public health nursing, which includes working with communities and populations, such as school-aged children and the elderly; conducting community assessments; surveillance; outreach; and intervening with aggregates and populations. These are essential parts of a baccalaureate preparation for public health nursing practice.

“We really need to do more than wait for a disaster or epidemic to occur.”

Susan Trossman is the senior reporter for The American Nurse.
that worked against nurses’ ability to provide the best clinical care,” Aiken said. For starters, there was the skill mix: two RNs and a few unlicensed staff to care for up to 24 or more post-op thoracic and burn patients.

“It was overwhelming,” she said. “I ran and ran and ran all night long. And when I got home, I had nightmares about what might have happened.”

Aiken wanted to “fix” the problems, such as inadequate skill mix and lack of administrative support for clinical leaders. Fortunately, she had many formal and informal mentors — especially UF Dean Dorothy Smith — who encouraged her to continue her education, delve into workforce and quality issues, and become a nurse activist.

Aiken now is known internationally as a nurse researcher, and her studies are widely quoted, including her research linking better RN staffing with better patient outcomes. Currently she and her team at Penn are conducting a large-scale study looking at how nurses are allocated in hospitals in 11 European countries, their patient outcomes, and patient lengths of stay, some of which are three times longer than those in the United States. Center researchers, many of whom she mentors, are also looking at safety issues, the use of supplemental nurses, and the cost effectiveness of RN care.

“We think of ourselves as myth-busters, and some of our findings have been controversial,” Aiken said. “But we are doing state of the science research on nursing issues fundamental to patient outcomes — and the viability of the nursing workforce.”

Rose Marie Martin, nurse-midwife & leader

When Rose Marie Martin, RN, OCN, stepped up to the podium last year to receive her ANA award for improving staff nurses’ professional and working lives, she shared the secret behind her achievements: She “showed up.”

“Just by stepping forward, doors can open up for you,” said Martin, a long-time staff nurse and Ohio Nurses Association (ONA) member. “And that can make a difference for you, for your co-workers, and for your patients.”

Martin began her career as a staff nurse in 1972, working primarily in pediatrics and occasionally in the emergency room of a rural hospital in northeastern Montana. Initially an LPN, she decided to become an RN and earned a diploma and then a bachelor’s degree in nursing. Along the way, she sharpened her professional skills by practicing in a range of specialty areas, including med-surg, critical care, and oncology.

Martin particularly enjoys providing varying levels of patient care, which she currently does as a staff and charge nurse on a bone marrow transplant unit at The Ohio State University James Cancer Hospital and Solove Research Institute in Columbus.

“Acyosity goes up and down as a patient moves through the transplant process,” Martin said. “The unit allows me to use my critical care skills, but it’s also a unit where I really get to know my patients and their families.” That personal interaction is important to Martin.

“So often as nurses we do things for our patients that aren’t ‘nursing-related’ and don’t seem that big to us,” she said. “But those little things can make a critical difference for our patients and their families.”

Martin also has a solid track record of “showing up” for her colleagues. She’s helped improve working conditions through stronger workplace contracts and staffing legislation. She’s mentored many nurses and promoted the implementation of clinical ladders in her facility. She’s been the president of her local bargaining unit and served on the board of directors of ONA, ANA, and the Columbus Chapter of the Oncology Nursing Association. And she’s continuing to enhance patient safety and nurses’ working conditions through the Nursing 2015 Initiative (http://nursing2015.wordpress.com/).

Martin acknowledges that nurses are born in many directions these days, but she believes it’s vital that they get involved in workplace, state, and national activities that can help strengthen their voice on work-related and patient care issues.

“When I was on the ANA board of directors, I saw how nurses worked together to identify future issues in advance and work to make sure we were at the right tables when solutions were being addressed,” Martin said. “By getting involved, you’ll realize how much influence you can have.”

Ginny Wangerin, nurse educator & advocate

There was no “aha” moment that led Ginny Wangerin into nursing. There was, however, a steady stream of role models in the small, rural Iowa community where she was raised.

“My grandmother was friends with the director of nursing at the hospital, and she asked her whether she could get me a job working in the kitchen,” said Wangerin, MSN, RN, president of the Iowa Nurses Association (INA) and nurse educator. “She [the director] told her that if I wanted to be a nurse, I should work as a nurse’s aide. So the hospital created a training program for high school students, and I became one of the first-ever high school students to work there as a nurse’s aide.”

“That absolutely set the course of my career, because I was nurtured by all those nurses who gave incredibly caring, individualized, quality care. Then when I graduated and was working nights on a med-surg floor, charge nurse took me under her wing.

“She showed me what it means to be a good nurse as an activist, and helped me expand into critical care and then education.”

Although Wangerin recently retired from her 30-year career at Des Moines Community College, she still consults around the state and teaches part time at the University of Iowa in her completion and graduate programs.

“I really enjoy teaching, sharing information, and helping people grow. As an educator you can really see the positive changes that occur as young students gain more experience,” Wangerin said. “And it’s still important for me to have a connection to our future.”

But she does have more time for her association activities. Wangerin represented nursing at one of the invitation-only White House regional forums on health care reform held by the Obama administration.

At the Des Moines meeting, Wangerin addressed the need for more cost-effective programs in Iowa to help the uninsured and offered strategies to improve access to care, such as expanding primary care centers’ hours and opening more health centers in rural areas.

“I also shared our concerns about developing a stronger health care workforce, including nurse educators, and making sure we have enough public health and school nurses who can provide wellness and disease prevention programs out in the community,” she said.

Wangerin prepared for the event by working with INA and ANA to determine top issues, but her commitment to nursing and long-time association involvement served her well.

“I never believed in checking in and out of life,” Wangerin said. “If there is a problem, don’t just complain. Figure out how you can be part of the solution.”

Margaret Onuska, certified nurse-midwife & leader

When it comes to women’s health, Margaret Onuska, MSN, CNM, likes “the ridiculously normal” — as in routine pre-natal care and annual exams. Onuska is a certified nurse-midwife at a private practice in Albuquerque, NM, and board member of the New Mexico Nurses Association (NMNA).

In her nurse-midwife role, she is able to spend more time with her patients than her physician colleagues. And that increased face-time — along with her own personal experiences — allows her to provide more holistic care and build the kind of rapport with her patients that can lead to positive changes in their overall health.

“I had a patient who came in for her annual exam who was fairly overweight, and I said ‘let’s put her health at risk,’” Onuska said. “We talked quite a while about the stresses in her life, and after that, we discussed nutrition and exercise plans.”

When the patient came back the following year, she had lost quite a bit of weight and was happier and healthier.

“I really like having a positive impact on somebody’s life,” Onuska said. “And I really enjoy working with women who are perimenopausal or menopausal. I can prescribe hormonal therapy if they are having problems. And I can talk — and sometimes even laugh with them — about things like that ‘tire’ around their belly that doesn’t seem to go away no matter how much they exercise. I can help them understand normal changes and encourage healthy habits.”

But her professional activities go beyond her current practice. While Onuska was working as an L & D staff nurse, a nurse anesthetist and some nurse-midwives at her facility encouraged her to pursue an advanced practice role.

Now a nurse-midwife for more than 20 years, Onuska is active in the American College of Nurse-Midwives, where she supports others interested in nurse-midwifery.

She also believes it’s important for nurses to belong to their state association and ANA, which she said represents the “whole of nursing.”

“NMNA’s membership is really diverse,” Onuska said. “We have nurse practitioners, OR nurses, public health nurses, and nurses who have moved on beyond hands-on care.” That diversity has helped NMNA to address a wide range of issues with state lawmakers.

“I know nurses tend to have a lot of irons in the fire,” Onuska said. “But I really encourage especially new nurses to carve out a niche of time to get involved, because there are a lot of important and exciting things they can do at the district and national level to improve nursing practice and patient care.”

Susan Trossman is the senior reporter for The American Nurse.
As a senior community health nursing supervisor for the Palm Beach County Health Department, Florida Nurses Association member Deborah Hogan, MPH, RN, is well-acustomed to stretching every penny to provide services to county residents in need. But her job — and those of other direct-care public health nurses around the nation — is getting much more difficult as government budgets continue to tighten at the same time the need for services increases.

Florida's unemployment rate in March 2009 was 9.7 percent with 893,000 jobless, an increase of 4.3 percent from the previous year, Florida’s Agency for Workforce Innovation noted. Florida also is among the states with the largest number of home foreclosures, according to published reports.

“Our economy here in Florida has been hit so hard,” said Hogan, who provides direct care to county residents and coordinates an immunization program for children and adults. “We’re seeing more people who’ve lost their jobs coming into the health department. Some have even said to us, ‘I’m sorry I have to come here, but my children need immunizations.' They don’t know that the public health system is for everybody.

“In addition, the number and complexity of the vaccines has also increased, which requires more time with each client.”

Florida public health nurses provide a range of traditional services, including prenatal care, well-child check-ups, epidemiological tracking, and disaster response. They now also are providing primary care to uninsured residents, who previously received care that in hospital emergency departments.

“Unfortunately, due to limited resources we are not able to do as many of the outreach activities that we used to do, such as visits to schools, community centers, and homeless shelters,” Hogan said. “And nursing positions were left unfilled because nurses would not accept the salary.”

Meanwhile, public health nurses in North Carolina also provide a range of clinical care. Statewide, its 85 local health departments generally receive 4 percent of their funding from the state, 16 percent from the federal government, and 80 percent from local sources, according to Joy Reed, EdD, RN, head of Public Health Nursing for the state of North Carolina and a North Carolina Nurses Association (NCNA) member.

“Every day is hurting, because all funding sources are being cut simultaneously,” Reed said. “Public health nurses here are seeing more clients, and we can’t turn people away because of their inability to pay.”

The net effect of this lopsided supply-and-demand is that nurses are working harder to get more people in for services, and they are spending less time with each person. It’s also taking longer for residents to get an appointment with their local health department, Reed explained.

Arlington County, VA, Public Health Nurse Manager Jeanne Matthews, PhD, RN, said that she not only is seeing an increase in demand for care, but also an increase in complexity of services needed.

“We're seeing more people whose primary language is not English, and we're finding we have far less time to provide the prevention-focused education that is so fundamental to our role,” Matthews said.

Trying to do more with less is just one of many issues facing public health nurses every day. Those issues include everything from trying to prevent childhood diseases from taking an upturn to worrying about the stability of their own jobs to explaining the importance of their role.

**Nurses also feel financial pinch**

In North Carolina, Reed reported that while public health nurses in her state still have jobs, many are being subjected to mandatory furloughs. They may be working four days a week and taking one unpaid day in an effort to balance their health department’s budget.

“That represents a 15 to 20 percent pay cut, which has a big impact on nurses’ own finances,” Reed said. “They also are staying much longer on the days they work to get everything done.”

In Arlington County, un-filled public health nurse positions have been frozen for roughly the past six months, which has helped to defray lay-offs at this point.

“We’ve been nip, nip, nipping at the edges of the programs we provide for so long,” Matthews said. “We’ve asked staff to do as much as they possibly can, and then some. Those cuts are painful to the community and to staff. But if there’s no money, we don’t have much of a choice. Unlike the federal government, we can’t print our own money.”

Looking at the national picture, there still are positions for public health nurses in some communities and states, and the long-term need for quality public health services — and nurses remains, according to Beth Lamanna, RN, MPH, WHNP, chairperson of the Public Health Nursing Section of the American Public Health Association and NCNA member.

“We are the first providers for vulnerable populations, we raise environmental health issues, and we are the front line for ensuring the public’s health,” Lamanna said. And public health nursing — with its focus on health promotion and disease prevention — may get more attention and hopefully funding with the increased emphasis on prevention in the health system reform proposals currently being debated.

But public health nursing has always faced challenges when it comes to recruitment and retention, largely because public health nurse salaries are not competitive with other nursing roles. Furthermore, public health departments traditionally are not inclined nor have the financial means to market this nursing role to new graduates or other nurses.

**Misinformation, demographic shifts present challenges**

In Palm Beach County, public health nurses have noticed what they fear could be a growing trend: parents refusing to vaccinate their children because they’re worried about a link between immunizations and autism. A recent Los Angeles Times story also reported that an increasing number of California parents have expressed similar concerns and are sending their children to school without being vaccinated.

“Misinformation is a critical issue in terms of prevention,” Hogan said. “There is a lot of misinformation about vaccines causing autism despite all the epidemiological studies that show otherwise and the vaccine courts saying there is no relationship.”

Childhood communicable diseases, such as whooping cough and measles, have not been an issue for decades because there have been effective immunization programs in place.

“But if this anti-vaccine sentiment continues, we’re going to see outbreaks that will impact the public’s health and we may even lose some children,” Hogan said.

In Florida, parents can refuse to have their children immunized because of religious reasons or if there is a medical contraindication.

Matthews said many young families don’t understand the impact these diseases can have.

“They have not grown up with children dying from measles or have experienced the ravages of polio,” Matthews said. “The recent measles outbreaks in the Washington, DC, metropolitan region illustrate the need for educating the public about prevention.”

On the positive front, a federal government advisory panel, the Interagency Autism Coordinating Committee, has been established to advise federal agencies and Congress on needs and opportunities for autism research. Hopefully, the research will bolster the case for childhood immunization, Hogan said.

Another challenge facing public health nurses on the front line is the ongoing increase in the number of non-English speaking clients who need services, Lamanna said. The cost for translators is a significant expense to public health departments. (In North Carolina, for example, clients speak 78 different languages.)

Beyond the language barrier, Lamanna said the wide-ranging diversity makes it increasingly difficult for public health nurses to provide culturally competent care because they lack essential resources.

Yet another related challenge centers on immigration status.

“In some states nurses are caught in the middle of erratic immigration policy,” Lamanna said. “They see a person in front of them who needs care, but they are being placed in a legal and ethical bind if they are required to determine a client’s immigration status.”

Finally, Matthews said she is hopeful that a renewed interest in and funding for public health nursing eventually will be on the upswing.

“We need to rearrange our priorities in this country,” she said. “We need policy change at the federal and state levels that emphasize the preventive side of health. It’s the only way we can significantly reduce healthcare costs and create healthier communities.”

For more information on public health nursing, go to www.apha.org/membergroups/sections/aphasections/phn or the Association of State and Territorial Directors of Nursing at www.astdn.org/index.html.
National Awards Program call for nominations

The ANA Committee on Honorary Awards is seeking nominees for the ANA National Awards Program, which recognizes nurses who have made significant contributions to the profession of nursing. Please take a moment to think about your colleagues who exemplify the special qualities recognized by these awards and nominate them for a national award. During the 2010 House of Delegates in Washington, D.C., ANA will bestow 14 national awards on the recipients at a ceremony in their honor followed by an opportunity to celebrate at a reception with other award recipients.

The nominees for all awards represent distinguished nurses who are nominated by the official submitters. Official submitters are permitted to provide nominations for the following awards categories:

1. All awards - CMA/ANA/IMD presidents or designees
2. Mary Ellen Patton Staff Nurse Leadership Award - Labor and workforce advocacy affiliates’ chairs or designees also
3. Staff Nurse Advocacy Award - CNPE, labor and workforce advocacy affiliates’ presidents or designees also

Nominee packets submitted to ANA by other sources will not be considered.

The deadline for receipt of complete nominee packets by the ANA Committee on Honorary Awards is Sept. 18, 2009. Nominee packets received after that date will not be considered. No extensions will be granted for incomplete nominee packets.

A copy of the ANA National Awards Program packet is available on Nursingworld at www.nursingworld.org/about/honoraward. The packet provides background information on the program and includes awards criteria, nomination forms for 14 national awards, a Checklist for Individual Nominee Packet, information on what constitutes a complete nominee packet, who can nominate individuals for the awards, and the name of the ANA contact person. Please share this information as broadly as possible to encourage submissions. Official submitters are encouraged to submit nomination materials electronically.

The official submitters need to carefully review and process all nomination materials that they receive for accuracy and completeness prior to forwarding them to the ANA Committee on Honorary Awards.

If you have any questions about the awards program, please contact Debra Evans, senior governance specialist in the Leadership Services department at (301) 628-5037 or e-mail: debra.evans@ana.org.

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CNOs use ANA standards, ethics, and quality titles in in-service training programs

With renewed emphasis on health care reform and the establishment of a new White House Office of Health Reform, U.S. hospitals are increasingly focusing on establishing and enforcing standards of care, ethics, and quality in health care. This has sparked wide interest among nurse executives seeking to train nursing staff and managers.

Nurse executives attending the American Organization of Nurse Executives’ (AONE) 42nd annual meeting stopped by ANA’s exhibit booth to pick up copies of the new third edition of Nursing Administration: Scope & Standards of Practice (The Standard) and stated that they frequently used the titles contained in ANA’s Foundation of Nursing in addition to the Nursing Administration Standard for in-service training. The Standard is a key resource for nursing leadership professional development and also a highly recommended resource for the American Nurses Credentialing Center’s (ANCC) nursing administration certification examination and the Magnet® Hospital application process.

Since early 2004, ANA’s Foundations of Nursing has generated mass appeal, particularly for college professors teaching fundamental nursing courses in baccalaureate, master’s and some doctorate-level nursing programs nationwide. This three-book package, appropriately named the Foundations of Nursing, contains ANA’s three foundational documents: Nursing: Scope & Standards of Practice, the new Guide to the Code of Ethics for Nurses: Interpretation and Application, and Nursing’s Social Policy Statement. These three books define contemporary nursing practice and belong in the hands of every nurse regardless of level, role, or setting.

AONE attendees were also particularly interested in examining ANA’s new ethical titles. They are already using the Guide to the Code of Ethics and have found it to be a powerful tool for teaching employees how to apply the provisions of the Code to professional practice. ANA’s latest ethics title, Genetics and Ethics in Health Care, explores ethical issues in health care associated with the latest advances in genetics and genomic science, while Nursing and Health Care Ethics provides a history of accomplishments and offers new directions to strengthen future scholarly contributions in nursing ethics.

For nurse executives assigned to improving nursing quality care, ANA’s new Sustained Improvement in Nursing Quality: Hospital Performance on NDNQI Indicators, 2007-2008 was of particular interest since many of their hospitals were already participating in the National Database of Nursing Quality Indicators (NDNQI)®. This book examines and documents the experiences of 13 well-performing hospitals participating in the NDNQI program.

Nurse administrators interested in examining any of these titles for possible incorporation into their in-service training programs should send an e-mail to Francine.Bennett@ana.org.

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ANA program goes mobile to keep nurses safe from chemical substances

By Susan Trossman, RN

ANA health and safety experts took their first receivers educational program on the road again, this time to a group of Ohio Nurses Association (ONA) members working at a major hospital in Cincinnati.

The program, “Hospital-Based First Receivers: Teaching Caring Professionals to Take Care,” is aimed at providing nurses with the information they need to protect themselves when working with patients who’ve been contaminated with chemical substances. “First receivers” are the staff who take over the care of patients brought to their facility by first responders, such as firefighters, hazardous materials teams, or paramedics. Hazardous chemical substances include pesticides, benzene, and other solvents.

“In many emergency situations, nurses often rush in to care for patients without thinking of potential risks to themselves,” said Holly Carpenter, RN, senior staff specialist with ANA’s Center for Occupational and Environmental Health (COEH). “We want nurses to understand what they are facing in the workplace and how to protect themselves and others from harm caused by hazardous substances.”

ANA is committed to promoting nurses’ right-to-know policy regarding hazards in the workplace, and this continues’ right-to-know policy regarding hazardous substances.”

“We have many rules and regulations to ensure patient safety and privacy,” she said. “But decontamination is something we don’t think about in our everyday lives.

“Let’s say, in the OR, we often see patients with gunshot wounds or who’ve been involved in an automobile accident shortly after they arrive in the hospital,” Beerman said. “We never think about what [substances] might be on their skin or clothes. We just react to a life-or-death situation.

“Although Beerman said that the hospital administration may have a plan to deal with hazardous situations, she believes most nurses don’t have the knowledge they need to prevent harmful exposures to themselves or others.

“We have had some previous training on hazardous substances when she worked in a Colorado ED, she found the program interesting and beneficial to her practice, particularly the tips Mahan offered about donning personal protective equipment.

“Handling mass casualties in the ED can be overwhelming,” Candage said. “ED nurses typically get hurried doing triage on a day-to-day basis in a busy department and could potentially miss a patient who’s contaminated by not asking the appropriate questions. This class was a good reminder to ask those questions and look for what we refer to as ‘red flags.’”

Candage also praised the format of the program, which she said was flexible enough to leave ample time for questions and discussion. During that time, Candage told nurse participants that, because every situation is different and dependent on the first responders’ resources, patients may or may not have been decontaminated at the scene. So patients need a full triage when they arrive at the hospital.

And Friedrichs said that although he had some limited experience working with patients who were harmed by hazardous substances, he appreciated learning more about the issue, particularly the toxicological effects of different chemical agents and how to treat them.

“I personally feel more prepared,” Friedrichs said. “And I feel every nurse should be trained about hazardous substances and how to protect themselves from exposure, especially in the times we’re living in. Nurses need to know that there are substances that can’t be just washed off and can continue to harm them. And nurses need ongoing training so that it becomes second nature to care for these patients when they come to the hospital.”

ONA nurses at the hospital hope to schedule a three-day course, as well as the five-day train-the-trainer offered by ANA’s COEH.

The program, which awards participants 6.74 CHs, is offered at no cost because of an educational grant from the National Institute of Environmental Health Sciences through ICWUC. CMAs or nurse members interested in the program can contact Holly Carpenter at (301) 628-5105 or holly.carpenter@ana.org.

ANA COEH Director Nancy Hughes and ICWUC Director of Education Bruce Mahan demonstrate the proper use of protective gear.
University program supports students, builds diverse nursing workforce

By Susan Trossman, RN

L et’s face it: Nursing school is not easy. It requires absorbing an immense amount of knowledge, performing intricate clinical procedures for the first time with some semblance of confidence, and learning that subtle changes in a patient’s condition definitely deserve a closer look.

There are, however, a group of students who are not merely making it through nursing school and beyond, but are thriving — thanks to an innovative program at the University of Massachusetts, Boston (UMASS-B) College of Nursing and Health Sciences.

The Nursing Scholars Program (NSP) is an initiative aimed at recruiting, retaining, and graduating up to 180 highly qualified nursing students who come from backgrounds usually underrepresented in nursing. They include students from a wide range of racial, ethnic, cultural, and socio-economic backgrounds.

The diversity these students bring to the classroom transfers to the nursing workforce, which has not reflected the diversity of the patient population.

“The program ultimately cycles back to the idea of how we can improve care,” said Linda Dumas, PhD, RN, ANP, a member of the Massachusetts Association of Registered Nurses (MARN), an associate professor of nursing, and NSP project director. “When patients have nurses who understand their culture, who can speak the same language, they will have greater access to care and receive better care. It’s really about strengthening the health care system overall.”

Getting started

The idea to reach out to underrepresented populations began several years ago with an anonymous grant of $10,000. Dumas used the money to complete a series of surveys to learn more about nursing students’ backgrounds and which aspects of the nursing program the students believed worked and which did not.

From there, she and her colleagues developed a program using the “culture of community” model, which was funded through a three-year workforce development grant issued by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The program was called “Bringing the Best to Nursing (BBN),” and it was the precursor to the NSP.

The culture of community model emphasizes strong student leadership, committed and supportive faculty, peer-to-peer mentoring and tutoring, and working partnerships with schools and health care facilities.

“Students learn from each other, and we learn from them,” said Dumas. And that model, which was the heart of the BBN program, is also integral to the NSP, now in its second year of a three-year HRSA grant.

There are a number of key components to the NSP, many of which originated with the BBN program. Those components include the following:

- Monthly, two-hour peer group meetings, in which students can share their experiences and concerns openly.
- Tutoring.
- Seminars on topics such as stress management and study techniques.
- Community mentors, specifically nurses who provide students with advice and career guidance.
- English-as-a-second-language classes.
- The use of computer laptops with computer skills support.
- A stipend or tuition waiver of $800 a semester for up to three semesters for qualified students.
- NSP leaders also conduct outreach efforts to identify potential nursing students in the greater Boston-area community.

In terms of faculty advising, Dumas said that it differs from the traditional approach in which faculty can be assigned many students whom they never really get to know.

“Our faculty advisors are there for the students,” she said. “I get to know all the students in the program, and they know I’m available: — and they don’t abuse it. Students are often surprised if they receive e-mail or a call from me or an advisor just checking to see how they’re doing. They generally are not used to faculty caring about them — let alone knowing who they are.”

Another program strength is the peer groups. All the nursing scholars are divided into peer groups of eight to 10 students who may be in different phases of the program. NSP students are required to attend, and faculty members and peer group leaders facilitate discussions on topics that are key to students’ continuing success.

“The students really help each other and learn from each other,” Dumas said.

To qualify for the program, students must be accepted into the nursing program and must be from an underrepresented population, which can refer to race, ethnicity, income level, or educational background. Students who have been part of the BBN or are in the NSP initiatives hail from all corners of the world, including Latvia, Brazil, Ghana, China, Morocco, and Poland, as well as from the United States, particularly the Boston area. In the BBN program, 53 percent of the students were black/non-Hispanic, and the same holds true for the NSP.

Dumas emphasizes that the program is not remedial. Students go through the same rigorous study as all nursing students. However, they have the support they need to better adapt to the university setting, be better socialized into the nursing profession, and boost their language or other important skills.

Being connected

Deb Washington, RN, is the director of Diversity and Patient Care Services at Massachusetts General Hospital, a MARN member, and a community mentor for the NSP and previously the BBN initiative. She became involved in the program because she wanted to stay in touch with her “own history” of not only having been a nursing student years ago, but also a nursing student who was a member of a minority.

“I remember what it was like to be a student and going through the same trials and tribulations that students go through today,” she said. “When I was in school, I didn’t have anyone I could turn to, or at least anyone I knew I could turn to, to help me.

Members of a minority may have a desire to move forward with life, school, or work, but they don’t have someone to sit down with them and help them through the process. Some of these students have parents who didn’t finish high school or go to college, so they don’t understand systems.”

Washington works closely with a MARN member, and Oklahoma City, and works in a cardiovascular ICU in Boston, as well as in a PACU at a community hospital. He credits his participation in the BBN program with building his confidence and communication skills, helping him prepare for his job search, and strengthening his professional skills.

Parena grew up initially in the Philippines and then in suburban Boston. He learned about the BBN program while taking a health assessment class from Dumas during his sophomore year.

He particularly enjoyed being part of a cohort comprised of about 15 mostly underrepresented students.

For more information on the program, go to www.umb/nsp/index.html.

Susan Trossman is the senior reporter for The American Nurse.

For more information on the program, go to www.umb/nsp/index.html.
**MNA efforts protect patient safety**

Maryland Nurses Association (MNA) members successfully blocked a state bill from moving forward that could have led to unsafe patient care.

Maryland S.B. 205 would have loosened requirements for nurses coming to the state to practice, according to MNA. For example, one provision of the proposed legislation would have allowed nurses licensed in another state or country to potentially practice in Maryland, even if they had no supervised clinical training. The Maryland Board of Nursing (MBON) could have waived the nursing clinical education requirement if the nurse had logged a certain amount of clinical work experience elsewhere and had met other licensure conditions.

MNA opposed this provision citing the following:

- Patient care would be compromised if a nurse does not have clinical training.
- Supervised clinical training is needed before a nurse obtains clinical experience.
- It opens the door for student nurses to graduate without clinical training.
- It creates a dual-track licensure system, by permitting nurses from other states and countries to obtain a Maryland license without clinical training, while requiring Maryland student nurses to complete clinical rotations.

“"All the nurses who contacted me and MNA found this legislation outrageous," said Nayna Philipsen, JD, PhD, RN, CFE, FACCE, co-chair of MNA's legislative committee and director of program development for Coppin State University in Maryland. "They said they couldn’t believe what they were seeing, and asked me if the medical board was going to waive the clinical education requirement for doctors next. They believe it’s just not safe for nurses to practice if they never had supervised clinical training. They know that nursing is an applied science.""

The measure also would have allowed the MBON to create and subsequently issue a temporary permit or license to RNs and LPNs who lacked one didactic course, such as medical, psychiatric, pediatric, or geriatric nursing. Under the legislation, nurses could hold a temporary license for up to a year and practice in clinical settings where that coursework supposedly wasn’t needed.

MNA argued that nurses should complete all parts of their education before they start taking care of patients independently.

MNA also pointed out that nurses often get pulled to other units, which means they could end up caring for patients beyond their scope. Further, within a given unit, there can be a broad range of patients.

MNA lobbyist Robyn Elliott said the association was successful in stopping the legislation because of strong grassroots efforts from members, the collaboration of other nursing organizations, and a series of discussions MNA leaders had with policymakers about the link between strong didactic and clinical preparation and patient safety.

Although the Senate passed the bill, the Maryland Department of Health and Mental Hygiene withdrew the bill from the House April 9, following a hearing in which MNA members provided key testimony. MNA and the MBON plan to participate in a workgroup to discuss issues in the bill over the summer. Elliot expects that legislation to address the larger education questions raised in this bill will be introduced in 2010.

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**Comparative effectiveness research testimony at IOM**

ANA offered recommendations in March to the Institute of Medicine (IOM) on ways to design health care studies that evaluate the work of nurses in improving patients' health and measure patient outcomes from nursing interventions.

IOM invited ANA, along with the American Medical Association and other health provider groups, to provide recommendations on how to allocate $400 million in the American Recovery and Reinvestment Act of 2009 (the stimulus bill) toward comparative effectiveness research. Comparative effectiveness research evaluates how different treatment therapies for a certain health condition compare to each other. The stimulus bill requires the IOM to submit a report to Congress and the U.S. Department of Health and Human Services by June 30 that provides recommendations for spending the funds.

In its testimony, ANA emphasized that studying how to maintain health and prevent disease are as important as how to treat diseases. Nurses have a major role in preventive and primary care services.

Among ANA's recommendations were the following:

- Incorporating the nursing performance measures tracked by ANA's National Database of Nursing Quality Indicators® (NDNQI®), such as patient falls, into the research agenda.
- Establishing research priorities based on the National Priorities Partnership's goals, such as engaging patients in managing their health. The Partnership is a coalition of national organizations, including ANA, working toward health care system change.
- Studying the delivery models that incorporate RNs, advanced practice registered nurses and other professions to determine the most effective collaboration models that produce the best health outcomes.

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**Recognition for a lifetime of giving**

In honor of National Nurses Week 2009, the American Nurses Foundation has established the ANF Legacy Wall at ANA headquarters in Silver Spring, MD. Inspired by conversations between ANF board of trustees President Margarete L. Zalon, PhD, RN, ACNS-BC, and friends and past presidents of ANF, this wall of honor highlights lifetime donors to the ANF Annual Fund who have contributed at least $10,000 to this worthy cause.

The contributors’ names are prominently displayed on plaques that will be seen by all visitors to ANA headquarters year-round. A bronze plaque indicates lifetime Annual Fund contributions of $10,000, silver indicates $25,000, gold indicates $50,000, and platinum indicates $75,000. Contributors who reach the $100,000-level of lifetime giving to the ANF Annual Fund will be recognized with a personal 8x10 framed photo on the wall.

At the center of the ANF Legacy Wall is the framed portrait of Julia Ondo Hardy, RN, honoring her donation of $2 million left by her estate in 1994 to support the mission of ANF. At the time, this was the largest bequest in the history of nursing in the United States. Hardy exemplifies the generosity of all contributors to ANF, who support the impact that ANF has on lives and the opportunities that ANF gives nurses. ANF continues to fulfill its mission of promoting the public health and advancing the nursing profession through its programs. One such program, the Nursing Research Grants Program, has awarded more than $3.5 million to more than 975 nurse researchers since 1955.

Every year individuals have so many good choices when choosing where to direct their annual charitable donations. ANF thanks its many contributors who make ANF a commitment as part of their charitable giving decision. All tax-deductible contributions are accepted online, by phone, or by mail. Already individuals have taken advantage of ANF’s pledge option in their Legacy Wall planning.

For more information on ANF, the ANF Legacy Wall, Nurses Rock the Foundation Endowment, the Honor a Nurse, and estate planning, visit www.ANFonline.org, or call (301) 628-5227. ANF is a not-for-profit, 501(c)3, organization. Gifts are tax-deductible to the fullest extent allowed by law; and support the mission of ANF.
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ANA-PAC is off and running again

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For more information on ANA-PAC, ANA members can go to www.ananeupac.org or contact Angela Song at angela.song@ana.org.

*as of 5/4/2009

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