Behaving badly?
Joint Commission issues alert aimed at improving workplace culture, patient care

By Susan Trossman, RN

Sticks and stones may break my bones, but names will never hurt me.

Downplaying the effects of verbal abuse has been the way of the world for decades in both the schoolyard and the workplace. But things are changing; The Joint Commission recently issued a “sentinel event alert” that’s aimed at stopping rude and disruptive behavior among health care professionals.

“Intimidation and acting out behavior creates a high-stress environment that’s incompatible with the culture of safety that we’re trying to promote in health care,” said Grena Porto, MS, RN, ARM, CPHRM, a patient safety and risk management consultant who serves on The Joint Commission’s Sentinel Event Advisory Group, which issued the alert. “It’s behavior that’s not limited to one group, and it’s been tolerated within health care organizations for too long.

“One of the underlying drivers is stress, partially because we have a staffing shortage. So people already come home feeling like they’ve gone several rounds in a boxing ring. We don’t need to add to it by allowing these behaviors.”

Long time coming

In promoting the alert, the Joint Commission noted that rude language and disruptive behavior are not just unpleasant for health care professionals who may be on the receiving end, but they also pose a serious threat to patient safety and the overall quality of care. The Joint Commission issues an alert to identify a specific sentinel (potentially harmful) event, describes its common underlying causes and recommends ways to prevent occurrences in the future.

The Joint Commission also is introducing new standards requiring more than 15,000 accredited health care organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior. The new standards take effect Jan. 1, 2009 and affect a range of organizations, from hospitals to home health agencies to laboratories.

“Most health care workers do their jobs with care, compassion and professionalism,” Joint Commission President Mark Chassin, MD, MPP, MPH, said in a statement. “But sometimes professionalism breaks down and caregivers engage in behaviors that threaten patient safety. It is important for organizations to take a

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Obama earns ANA endorsement

Given his stances on important nursing and health care issues, ANA has endorsed Sen. Barack Obama (D-IL) for president of the United States.

“As president, Barack Obama will bring real change to our health care system,” said ANA President Rebecca M. Patton, MSN, RN, CNOR. “Nurses are consistently voted the most trusted profession by the American people, and we, as a profession, trust that Barack Obama will see that affordable quality health care is made available to everyone.”

NURSES for BARACK

Hearing of ANA’s support, Obama said, “I am honored to receive the endorsement of the American Nurses Association. The nurses of America serve our country tirelessly, and I share their belief that we must bring affordable and accessible health care to all Americans. My plan lowers health care costs for the average American family by up to $2,500 and finally makes health care work better for American families than it does for the drug and insurance companies.”

Added Patton, “Both Senator Obama and Senator Clinton spoke at ANA’s House of Delegates in June about the need to move forward in unity to bring about real, much needed change to our health care system, and our nurses re-

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The future of health care is dependent on you… not just ANA

I n a matter of weeks, we will witness a spectacular moment in United States history as we elect our next president and vice president. For the first time, either an African-American president or a female vice president will be elected. Despite the constant barrage of campaign positions, responses and negative ads, I can not wait to watch the election returns Nov. 4 and see whom America elects.

Throughout the years, ANA has occupied a front row seat in many of the activities that have gotten our country and our profession to this historic moment. This year has been no different. ANA has had some “first” experiences this year. We have had and continue to have direct access to most presidential candidates. Some candidates solicited ANA’s feedback on their health care platforms. The Republican National Committee’s (RNC) Healthcare Platform Committee invited the ANA president to meet and discuss ANA positions during the RNC’s Healthcare Platform, which was presented at its convention. All candidates would like to have ANA’s endorsement.

As ANA president, I joined Hillary Clinton on the campaign trail in Virginia and flew with her for almost six hours from Washington to Seattle on her private campaign jet. We traveled first class with the vice president. If you travel in other state, ANA and the nursing profession had more than just a seat in the front row. In Seattle, in front of a capacity crowd, I introduced Sen. Clinton. I shared with the audience that her history and proposed health care plan matched ANA’s desired future for quality, accessible, cost-effective health care utilizing the full scope of practice for all registered nurses, not just advanced practice nurses. I shared that bedside nursing needs functional changes to maintain an adequate supply of RNs and that the senator understands and supports many of ANA’s initiatives and positions to support staff nurses.

I am proud that our past ANA leaders recognized the opportunities and importance for ANA to be engaged in our country’s political process. It is one of the many reasons I joined ANA and my state association as a new nurse. It is the reason many become and stay members. No other nursing organization has the number of front row seat opportunities that ANA has. Though it is controversial at times with our membership, ANA involvement has delivered results that no other nursing organization has achieved. ANA has invested your membership dollars to build the internal structure that has resulted in numerous successes and milestones for ANA, the state associations, individual nurses, and most importantly, the patients we care and advocate for. Recently I visited with past ANA president Jo Eleanor Elliott. She was president during the times when ANA advocated for health care reform in the ’60s. She was invited to the White House and was a witness when the legislation creating Medicare was signed into law. Nursing was there in the front row.

Let me be clear: Despite all that ANA has achieved for every patient and nurse in this country, this editorial is not about ANA owning the political power in nursing. Our patients, your practice, and your role as a registered nurse require all of us to engage in the presidential and congressional elections and even your local elections. Our organizational affiliates provide great leadership and support to many nursing issues. At the Democratic and Republican national conventions this summer, both Association of periOperative Registered Nurses and American Association of Nurse Anesthetists joined and partnered with ANA in our health care event, which achieved more acknowledgement and publicity for needed health care reform.

But as individuals and collectively, there is great political power to be realized this year in the races. You know that every vote counts. If you need convincing, I suggest you talk with the nurses in Florida. To be perfectly honest and blunt, not all nurses vote. Yes, not all Americans vote either. Still not a valid excuse in my mind. You know what is at stake by not voting and selecting the candidates that best represent the plan and hope to lead the needed reform in our country and health care system. ANA’s Web site (www.nursingworld.org) provides a list of the candidates who we have endorsed. Our process is fair and provides a list of those we believe represent the best interests of our patients and profession.

Yes, we are all busy. What nurse is not? We need to vote and make sure our voice is heard. I plan to vote by absentee ballot. In fact, I have voted this way for several years now. It is sooo easy. My schedule as a nurse challenges my ability to get to the voting booth on time. Polls open after I leave for work and are often closed before I get home. An absentee ballot ensures I can vote and I can do it at home and use resources like the ANA Web site. Think about the great impact this could create. Please encourage all nurses to vote—including by absentee ballot—to ensure health care reform takes a front row seat with our representatives.

Global issues

Just a small complaint about an article that appeared in the informative July/August 2008 issue. I read about a resolution passed by the ANA House of Delegates under “Global Issues.” As if nurses’ plates aren’t full enough, we are now encouraged to jump on the politically correct global warming bandwagon.

Back in the ’70s I used to belong to the Sierra Club. The question then was, “Is there an Ice Age?” The answer then had us environmentalists worried about the growing threat of glaciation. Now there’s been a complete flip flop, and it’s all about politics, money, control, more money and a Nancy Pelosi like urge to “save the planet.”

Unfortunately, many climatologists and people with just plain common sense are debunking this hoax. It’s the weather, stupid, and it changes all the time. In Minnesota where I live, the land has several times been under a mile of ice. Somehow it warmed up, and we actually use air conditioners in the summer. When the glaciers melted, there were no evil SUVs, no power plants, no airlines to carry delegates to conferences, and no hard working nurses hyperventilating and emitting the carbon dioxide Al Gore preaches will burn us all up—unless we buy from his carbon trading company.

Let’s stick with the traditional, fundamental nursing issues instead of wasting time and using energy pro-

Letters To The Editor

See Global issues on page 14.
ANA has long advocated for the ethical recruitment of foreign-educated nurses. In April 2008, the association filed anamicus brief in New York supporting a motion to drop criminal charges against a group of Filipino RNs. These nurses had been charged with patient endangerment after responding to a 911 call. They came to be known as the “Sentosa nurses.”

The nurses had been recruited by the Sentosa Recruitment Agency to work at specific nursing home facilities on Long Island. When they arrived in the U.S., the “good faith” they actually were working for a staffing agency, Prompt Nurses Employment Agency. Over a period of months, the nurses said, the agency refused to pay them according to the terms of their contracts. They also said they were not properly trained for their new jobs and were required to care for more patients than they could handle safely.

The code is designed to increase transparency and accountability throughout the process of recruitment and provides guidance to health care organizations and recruiters on ways to ensure recruitment is not harmful to source countries.

In addition to the ANA, the code has also been endorsed by numerous groups, including the American Association of International Healthcare Recruitment, the National Council of State Boards of Nursing, the National Association for Home Care and Hospice, several large recruiters, and multiple associations of foreign-educated nurses.

A copy of the code is available on ANA’s Web site at www.nursingworld.org in the “announcements” section.

LA landmark legislation on disaster care

Louisiana was hit again — this time by Hurricane Gustav. But nurses and other health care professionals now have state laws that will help protect them and their patients during disasters that can cause extreme working conditions.

Louisiana Gov. Bobby Jindal (R) recently signed into law the last of three pieces of legislation that will apply only during declared disasters and cover physicians, nurses and other health care personnel, including those coming from other states.

In passing these three bills without a single dissenting vote, the legislature recognized that care during disasters is given under unusual circumstances in conditions that are far from traditional, and that protecting medical judgment under such conditions is a necessity, according to the bills’ supporters.

Organizations involved in passing the landmark legislation are the Louisiana State Medical Society, the Louisiana State Nurses Association and the Louisiana Nurse Anesthetists Association.

These measures apply to all cases of declared disasters, such as terrorist acts, chemical or petroleum plant explosions and pandemics, as well as tornadoes and other natural events. They were spurred by events surrounding Hurricane Katrina and the arrest of three health care professionals who stayed and served patients in need during the storm, only to be accused of criminal wrongdoing in the deaths of nearly 40 stranded and acutely ill hospital patients by the state’s then-attorney general. A grand jury ultimately found no cause for pursuing the allegations.

However, several family members of patients filed civil suits in the wake of the attorney general’s actions. Some of those civil suits are still pending in Orleans Parish courts.

Louisiana S.B. 330: This measure amends the state’s “Good Samaritan Statute” to protect health care professionals whether they are compensated for their work or not. This is an important change because most health care professionals are working during a disaster. The original statute only offered civil protection if services were “gratuitous.” In addition, the measure protects medical personnel from “simple negligence” and only allows liability for “gross negligence” and “willful misconduct.”

S.B. 301: During disasters, reverse triage protocols are often put into use, with those patients not expected to survive being the last to be evacuated. This measure gives immunity for simple and gross negligence by doctors and nurses, thereby, protecting them from civil damage to patients as a result of evacuation or treatment (or failed evacuation or treatment) at the direction of the military or government in accordance with “disaster medicine” protocols. For the first time, a state statute defines disaster medicine as “patient care” under circumstances when the number of patients exceeds normal medical capacities. The statute recognizes that medical personnel should not bear civil liability for such disastrous situations unless involved in intentional misconduct.

1379: This legislation allows for the creation of a disaster medicine review panel that would render an independent opinion regarding medical judgment using scientifically reliable evidence. It also states that the standard of care of medical personnel is established as “good faith medical judgment” given the disastrous circumstances under which the judgment was rendered. Further, the prosecuting authority will refrain from arresting medical personnel until the opinion is rendered and any action is needed.

ICN names new CEO

David Benton has been appointed as the new chief executive officer of the International Council of Nurses (ICN) beginning Oct. 1.

He takes over the key post from Judith A. Oulton who is stepping down after 12 years at the helm.

“After looking forward to working with David in his new role as CEO, as he continues and advances the tremendous work of Judith Oulton, leading nurses and the populations they serve to quality health care for all,” ICN President Hiroko Minami said. “His broad management experience, special expertise in professional regulation and education are key assets for ICN as we continue to strive toward our vision of leading societies to better health.”

In accepting the position, Benton said, “This is an exciting and challenging time for nurses everywhere, as governments, health systems and international agencies address the human resource crisis and global health priorities. The nursing role is pivotal. Worldwide nurses are responsible for delivering care with innovative solutions that need to be shared, recognized and replicated. I look forward to working with all our partners to generate synergies of innovation and effort that will improve health outcomes for all and strengthen our profession.”

Benton has served as consultant in nursing and health policy at ICN since 2005, specializing in regulation, licensing and education. Prior to coming to ICN, he filled senior management roles across a range of organizations over the past 20 years. These roles included executive director of nursing in posts in Scotland and England; chief executive and accounting officer at the National Board for Nursing Midwifery and Health Visiting of Scotland; and regional nurse director, Northern and Yorkshire Region, United Kingdom.

He has received several awards and honors, including being presented with Fellowship of the Florence Nightingale Foundation in 2001 and awarded Fellowship of the Royal College of Nursing of the United Kingdom in 2003 for his contribution to health and nursing policy.

Based in Geneva, Switzerland, ICN is a federation of 131 national nurses associations.
associations representing the millions of nurses worldwide, and ANA is a founding member.

RWJF Foundation names fellows

A Minnesota Nurses Association member and six other health professionals — all with a wide range of academic and community-based experience — have been named Robert Wood Johnson Foundation Health Policy Fellows for 2008 to 2009.

Established in 1973, The Robert Wood Johnson Foundation Health Policy Fellows — the second-oldest active program of the Robert Wood Johnson Foundation (RWJF) — is designed to develop the capacities of outstanding mid-career health professionals in academic and community-based settings by providing them with an understanding of the health policy process. The program is administered by the Institute of Medicine of the National Academy of Sciences.

Earning one of these prestigious positions is Margaret P. Moss, PhD, RN, JD, associate professor and chair of the Leadership, Systems, Informatics and Policy Co-operative in the School of Nursing at the University of Minnesota, as well as director of Inclusivity and Diversity.

Each year, fellows are selected on a competitive basis and leave their academic settings and practice responsibilities to spend a year in the nation’s capital. A three-month orientation program is followed by a nine-month assignment, in which fellows work in a congressional office or the executive branch. Following the one-year experience, fellows return to their home institutions or practices to assume leadership roles in improving health policy and management.

The fellows bring much needed practical knowledge of the health care system to Washington, DC, where they can help our nation’s leaders work to improve care,” said Michael Painter, JD, MD, RWJF senior program officer and 2003-2004 Robert Wood Johnson Health Policy Fellow. “The ‘hands-on’ health and health care experience they bring positions them to have a substantial impact on the nation’s health care policy.”

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

Celebrate med-surg nursing

The Academy of Medical-Surgical Nurses (AMSN) has designated Nov. 1 to 7 as “Medical-Surgical Nurses Week” to encourage hospitals, facilities and other employers to honor the nurses who provide compassion and care to adult patients and their families.

This nationwide celebration will recognize and reward medical-surgical nurses, one of the largest groups of practicing nursing professionals in the health care industry. Medical-surgical nurses possess specialized skills and knowledge of the entire spectrum of nursing care. They promote excellence in adult health, provide quality care for patients with diverse conditions and educate patients, families and peers and other health care professionals.

This will be the second year for the weeklong celebration.

“Medical-surgical nurses practice in a variety of settings and care for a broad range of patients,” said AMSN President Kathleen Reeves, MSN, RN, CNS, CMSRN, who’s also a Texas Nurses Association member. “This is a perfect time to thank medical-surgical nurses for all that they do.

To participate in this annual celebration, employers and facilities are encouraged to honor their medical-surgical nurses. As in previous years, activities will include special events, luncheons, education programs, special presentations and proclamations from local governments.

In addition to appreciating RNs during Medical-Surgical Nurses Week, Reeves said AMSN promotes the event to spark interest in other nurses about the diverse career opportunities available in the medical-surgical field.

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

Scholarships to widen pipeline

Fifty-eight schools of nursing will receive funding through The Robert Wood Johnson Foundation (RWJF) New Careers in Nursing Scholarship Program, which aims to strengthen the nation’s pipeline of new nurses by providing financial aid to students who enroll in fast-track nursing degree programs, the foundation and the American Association of Colleges of Nursing (AACN) recently announced.

Scholarships of $10,000 each will be awarded to 706 nursing students in accredited programs during the 2008 to 2009 academic year.

“Schools of nursing nationwide are grateful for the exceedingly generous commitment the Robert Wood Johnson Foundation has made to help alleviate the U.S. nursing shortage by stimulating growth and innovation in baccalaureate and graduate nursing programs,” said AACN President Fay Raines, PhD, RN. “As the National Program Office for this groundbreaking initiative, AACN was pleased to see the high caliber of funding proposals submitted by schools of nursing and delighted that so many students who need financial assistance will receive support as they embark on their nursing careers.”

The RWJF New Careers in Nursing Scholarship Program was created to enable schools of nursing to expand entry-level accelerated programs at the baccalaureate and master’s levels. Grant funding is disbursed to schools of nursing, and these institutions then award individual scholarships to students. Scholarship award preference is given to students from groups underrepresented in nursing or from disadvantaged backgrounds. Institutions receiving awards will use this funding to help secure new faculty resources and provide mentoring and leadership development resources to ensure successful program completion by scholarship recipients.

By bringing more nurses into the profession at the baccalaureate and master’s degree levels, the new scholarship program also helps to address the nation’s nurse faculty shortage.

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

Straight talk from nurses

For parents of sick children, one of the most important measures of quality hospital care is how well nurses communicate about treatment, tests and pain management.

In the July-August 2008 issue of Pediatric Nursing, Susan Hong, MS, FNP-C, RN, and her co-authors explore the relationship between nurses’ communication and pediatric parents’ satisfaction. The authors studied the pediatric unit of a United States teaching hospital on the West Coast. The unit had received a lower than 50 percent rating for nurse communication.

According to the authors, parents prefer language they can understand — not medical terminology, as well as assurance from caregivers in uncertain situations. They also want to build a sense of trust with nurses and health care providers.

In the study, the researchers tested the hypothesis that patient and parent satisfaction ratings would rise if an inservice with nurses’ communication was offered and if a handout was given to parents regarding effective pain management.

The authors surveyed 50 randomly selected parents of discharged patients before and after these interventions took place.

In their findings, the authors report there were positive trends in nurse communication cited by the parents after the interventions (an increase from 81.6 to 85, and 82 to 85% for satisfaction), nurse instructions for treatments and tests (78 to 82 percent) and for pain management (80.8 to 82.4 percent). As a result, the pediatric units of the hospital now provide the handout to parents of patients with pain issues, and the authors recommend that inservice nurses also may be a useful intervention, according to the article, “Parental Satisfaction with Nurses’ Communication and Pain Management in a Pediatric Unit.”

Get vaccinated

Joint Commission Resources (JCR) has launched a “Flu Vaccination Challenge” to underscore the responsibility that hospitals have to help keep their employees and patients healthy this influenza season. The challenge aims to increase flu vaccination rates among health care workers. According to the Centers for Disease Control and Prevention (CDC), in the 2005-2006 season, only 42 percent of surveyed health care workers received a vaccination. In past years, influenza infections have been documented in health care settings, and health care workers have been implicated as the potential source of these infections. JCR challenges hospitals to achieve higher vaccination rates among their staff.

The challenge began in September and will continue through the influenza season until May 2009. Hospitals that achieve a vaccination rate of 43 percent or more will be recognized for their dedication to helping their employees healthy and helping to protect their patients. Vaccination of health care workers may help to decrease the chances that they will get the flu and pass it on to their patients.

“The Flu Vaccination Challenge highlights for health care workers the value that flu vaccinations can have on patient safety,” said Barbara M. Soule, RN, MPA, CIC, practice leader, Infection Prevention and Control Services, JCR. “Doctors, nurses, technical and administrative staff may care for patients with compromised immune systems including the elderly and people living with a chronic disease. As a professional devoted to ‘do no harm,’ flu vaccination gives me an opportunity to help protect my patients by decreasing the chances that I will get the flu and pass it along to my patients.”

The flu is a serious disease that can potentially be fatal. The CDC’s Advisory Committee on Immunization Practices (ACIP) recommends an annual flu vaccination for a number of groups, including adults at high risk of complications from the flu and those who are in contact with them, including health care workers. Efforts to increase vaccination coverage among health care workers are supported by various national accrediting and professional organizations including The Joint Commission. Since Jan. 1, 2007, the Joint Commission has required accredited hospitals, critical access hospitals and long term care organizations to offer the influenza vaccination annually on site to staff and licensed independent practitioners.

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

Get a flu shot

A new study from DoctorDirectory.com of more than 850 physicians of all specialties was designed to assess attitudes on universal health care as it relates to the upcoming election. Regarding the health care debate and the election, 81.3 percent have formed party and candidate preferences based upon the candidate’s stand on key issues.

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Behaving badly
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stand by clearly identifying such behaviors and refusing to tolerate them.”

Since it came out, nurses who have been exploring the issue for several years say that much of the press around the alert has focused on bad behavior on the part of physicians.

Kim Murray, founder and principal of QRS Healthcare Consulting, LLC, explained that studies have shown that physicians who act out have a more profound effect, because of their relative power.

There also have been several celebrated cases reported in the media of physicians having temper tantrums. Case in point: In August, the Boston Globe wrote about an orthopedic surgeon who threw a pair of scissors in the OR, narrowly missing a nurse.

Many nurses can speak to their reluctance to phone certain physicians for fear of incurring their wrath. Nurses exploring workplace bullying, however, say their colleagues must look beyond the nurse-physician relationship when developing and implementing the new Joint Commission standards and alert recommendations.

“When I heard about the Joint Commission alert, I was absolutely thrilled and felt it was long overdue,” said Col. John Mur-ray, PhD, RN, CPNP, CS, FAAN, president of the Federal Nurses Association (FedNA). In 2006, FedNA successfully gained support from nurse leaders nationwide for a resolution introduced at ANA’s House of Delegates and aimed at stopping unhealthy work behaviors, such as bullying, hostility, lateral (peer-to-peer) abuse, intimidation and abuse of authority.

They introduced the HUD resolution because nurse members recognized bad workplace behaviors as an escalating problem occurring in all settings where nurses practice, learn, teach, research and lead—and in hospitals and academic institutions, large and small, rural and urban.

Murray frequently speaks on workplace bullying throughout the United States and beyond. And when nurses who’ve been in abusive situations approach him afterward, none describe their perpetrators as physicians. Instead, they generally mention nurse leaders, such as nurse managers and executives. Also nurses who report problems may not be taken seriously.

Ramón Lavander, MSN, MA, RN, FAAN, director of Communications and Strategic Alliances for the American Nurses Association (ANA), which has focused on bullying in the workplace for over a decade, notes that while much of the focus has been on workplace bullying, the problem occurs in all settings, including schools, long-term care facilities and nursing homes.

In 2006, AACN co-conducted a workplace survey of some 4,000 critical care nurses, who averaged 17.5 years of experience. Sixty-five percent reported experiencing at least one incident of verbal abuse in the past year from a physician (the most common), nurse manager, other RN, patient or other person. Although 47 percent said their facility had zero tolerance policies in place outlawing this type of abuse, only one in four nurses reported that their facilities were fully committed to enforcing them.

On the case

A developmental pediatric nurse practitioner, Judith Vessey, PhD, CRNP, MBA, FAAN, found herself diving into the world of teasing and bullying in relation to its effects on children. The Boston College nursing professor has since been engaging in a series of studies on nurses and bullying with an eye toward developing effective interventions to ensure a better workplace.

In one of her more recent projects, Vessey and colleagues created an online, 30-question, nationwide survey to capture a snapshot of the experiences of RNs, including staff nurses, educators and administrators. The survey also included an open-ended question that allowed nurses to expand freely on bullying in the workplace.

She defines bullying specifically as something that is repetitive, has a real or perceived power differential between the person doing the bullying and the targeted person, and has an intent to harm. (Lateral or horizontal abuse takes out the power differential, but still is designed to cause upset. Harassment has many of the same qualities of lateral abuse, but is covered by a set of legal protections.)

“At the time, we didn’t think we’d get many responses to the open-ended question, but two thirds of the nurses responded and wrote paragraphs and even pages describing their experiences,” said Vessey, a Massachusetts Association of Registered Nurses member. “Many of the nurses talked about lateral violence or harassment. In their minds, it’s all the same.”

Through their research, they discovered that nurse-to-nurse bullying is a major problem in need of evidence-based interventions. She added that individuals who are most at risk for being bullied are those who are different from the group, such as new nurses, float nurses or those of a different race, ethnicity or gender.

The fact that nursing is a traditionally female profession that exists in traditionally hierarchical environments doesn’t help. “When bullying others, boys have tended to use fistfights, and girls have used social toxicity [for example, ostracism or manipulation through gossiping and rumor-spreading],” Vessey said. “And if social toxicity worked for them in sixth grade, it’s likely to work for them on the unit.”

Through his interactions with nurses, Murray said that a prime factor behind health care professionals participating in rude, condescending or other abusive behav-iors seems to be more about personal-ity type than just working under stressful conditions.

Dianne Felblinger, EdD, MSN, WHNP-BC, CNS, RN, believes incivility is far more prevalent in nurses’ workspaces than physicians’ workplace. She defines incivility as a behavior of low intensity, of ambiguous intent to harm and in violation of workplace norms. It includes behaviors such as refusing to work collaboratively, gossiping and emotional tirades.

She added that civility needs to be part of orientation and annual continuing education programs, like CPR and bloodstream pathogens,” said Felblinger, also an expert on inappropriate workplace behaviors and a professor at the University of Cincinnati’s College of Nursing.

However, she noted that when bullying occurs, the targets of abuse wait an average of 22 months before they report it. Nurses and others who believe they are experiencing a great deal of anxiety and depression, as well as post-traumatic stress disorder and physical problems.

And then there is the issue of patient care.

Nursing requires quality teamwork, and a direct cause and effect of bad behaviors on patient outcomes is not always obvious, according to Vessey.

If nurses are dissatisfied with their jobs because of the work environment, they don’t want to go to work or be fully engaged. This leads to an unstable and disengaged workforce and ultimately poor patient care conditions.

Added Felblinger, “In health care, we’ve always taken a stern approach to our roles, because what we do is so serious and important. But how we treat ourselves and each other are tied to patient safety and quality of care. So changing the culture would be very, very helpful to health care professionals and patients.”

Education and enforcement

AACC has been a leader in working to promote healthy workplaces for RNs—devoid of bullying, condescending behaviors, a refusal to answer questions, angry outbursts and physical contact.

In 2004, the association issued a position statement calling for zero tolerance toward abuse. In that position statement, it noted that 12 percent of nursing turnover was directly attributed to factors associated with verbal abuse. A year later, the association produced the AACC Standards for Establishing and Sustaining Healthy Work Environments, the first national standards to address key workplace practice components. These include the need for nurses and other health care profession-als to achieve skilled communication, true collaboration and meaningful recognition of what each group brings to the table.

The standards support provisions out-lined in ANA’s Code of Ethics for Nurses and “provide a framework to assist nurses in upholding their obligation to practice in ways consistent with appropriate ethical behavior,” according to the AACC standards document. The document identifies a critical element of skilled communication, for example, noting that organizations’ policies should eliminate abuse and disrespectful behaviors in the workplace. It also requires facilities to establish systems in which individuals and teams formally evaluate how communication affects clinical, financial and work environment outcomes.

Another standard calls for nurse leaders to embrace, as well as authentically live and engage others in achieving a healthy work environment. Among the elements needed to meet this standard is one that requires facilities to develop mentoring programs for all nurse leaders. Another states that facilities give nurse leaders the financial and human resources needed to sustain a healthy work environment.

“AACN believes that maintaining a healthy workplace is a shared responsibility between the individual and an organization,” said Lavander, a member of the Guam Nurses Association. “An organization can establish all the policies it wants. But if it doesn’t foster the positive development of the skills needed and individu-als don’t embrace them, it’s a senseless policy. It’s also unethical.”

Porto was instrumental in creating the alert and knows that health care organizations have been reticent to admit that they may have a workplace culture problem.

“I saw this as a huge issue while working with facilities to establish a culture of safety and build teamwork,” Porto said. “There was a lot of denial. Or if a nurse complained, a colleague or manager would say, ‘Oh grow up, he’s a jerk. Just do your job.’”

She added that nursing supervisors often enabled abusive behavior by assuming a referee role and not focusing on stopping the abuse—particularly when it came to working relationships with physicians.

“None of the professions have taught their students how to talk with someone who gets out of control, or how not to get out of control themselves,” Porto said. “Training and education are important, but that doesn’t change the behavior by itself. You need zero tolerance, and it has to be enforced. That’s what is called for in the alert.

“And discipline is an appropriate response to this type of behavior,” she contended. “If somebody was a jerk at you in the OR, it shouldn’t be a ‘let’s go get a cup of coffee and talk about this response.’”

To help put an end to intimidating and disruptive behaviors among physicians, nurses, pharmacists, therapists, support staff and others, the Joint Commission alert recommends that health care organizations take 11 specific steps, including the following:

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New book from ANA on faith community nursing

In 2005, the ANA and Health Ministries Association co-published Faith Community Nursing: Scope & Standards of Practice. These standards articulated the professional expectations of faith community nursing for all care levels and settings. A faith community nurse promotes health as wholeness within a faith community—its groups, families and individuals—through the practice of nursing. Knowledgeable in both nursing and spiritual care, the faith community nurse provides spiritual care for a faith community in the context of its values, beliefs and practices, whatever its faith traditions may be.

Now, ANA has published a second book on faith community nursing: Faith Community Nursing: Developing a Quality Practice, by Carol J. Smucker, PhD, RN, and Linda Weinberg, DNSc, RN, CRNP, contributing author. Grounded in ANA’s Faith Community Nursing: Scope & Standards of Practice, this new book is an authoritative, balanced and in-depth guide to faith community nursing practice and the daily challenges and realities of working in a faith community setting. Organized as a quick reference for the busy faith community nurse, the book includes information for developing a quality health ministry program in a faith community. In the book, the authors describe their personal experiences working in Christian and Jewish congregational settings to emphasize the variety of faith community settings, types of positions and diverse educational backgrounds of faith community nurses.

To find out more about Faith Community Nursing: Developing a Quality Practice, Faith Community Nursing: Scope & Standards of Practice and other ANA publications, go to www.nursesbooks.org.

ANA CEO takes part in interview series

Linda J. Stierle, MSN, RN, CNA, BC, chief executive officer of ANA took part in the health08.org Kaiser Family Foundation interview series Viewpoints: The Health Care Debate with various leaders of organizations representing health care providers, insurers, policymakers, employers, labor unions and consumers. She shared her views on shortcomings in the nation’s health care system and how it could be improved.

“Comprehensive health care reform is one of the most pressing issues facing the nation today,” Stierle said. “Lack of health security and access to affordable health care should be a priority for the incoming administration, especially since there are 47 million people uninsured in the U.S.”

With the general election campaign entering its final two months, health08.org, the Kaiser Family Foundation’s Web site for election news, analysis and events, is presenting seven additional interviews with health care leaders exploring what they think the next president and Congress should do to make the health system work more effectively and what they think the biggest hurdles are to improving health care.

In these new interviews, Kaiser’s Jackie Judd talks with leaders from the American Academy of Family Physicians and the Partnership to Fight Chronic
A bridge between countries built by nurses

By Susan Trossman, RN

Travelling to Vietnam from Colorado and Wyoming is not exactly a quick trip. But Sara Jarrett, a Colorado Nurses Association (CNA) member, and Mary Behrens, a Wyoming Nurses Association member, have made that 20-plus hour, multiple-stop plane trip routinely over the course of more than a dozen years.

The two’s goal – along with other nurse educators from around the United States – has been to help nurses in Vietnam build more comprehensive, nurse-run educational programs, and in turn, strengthen nursing care delivered in hospitals and in their communities. And along the way, Jarrett, EdD, RN, and Behrens, MSN, RN, FNP-BC, have made lasting friendships that also fuel their desire to return again and again.

In the beginning …

Jarrett became involved in this U.S.-Vietnamese nurse collaboration through an organization called Friendship Bridge, which in 1989 created a program to send much-needed medical supplies and medications to Vietnam. She knew its founders, Connie and Ted Ning, through an earlier humanitarian project — Friends of Children of Vietnam — which provided support to orphanages during the war.

“We soon realized that we were not meeting the health care needs of the country by just sending supplies and equipment,” Jarrett said. So in 1991, she and two other Friendship Bridge volunteers — CNA member Kathleen Whitney, MS, RN, ANP, and Karen Terry, MS, RN, a nurse from The Children’s Hospital in Denver, CO — traveled to Ho Chi Minh City in Vietnam to assess both nursing conditions in hospitals and nursing education programs.

“What we learned is that nurses were struggling to provide health care with minimal resources,” Jarrett said. “For example, they had no way to clean tubs that were used to treat burn patients, so patients experienced a lot of infections and pain.” (The organization ultimately shipped boxes of bleach, among other supplies, to the facility.)

Jarrett and her colleagues also determined that although nurses in Vietnam had bachelor’s degrees, they were trained primarily by physicians and were very limited in their scope in practice. Physicians generally viewed nurses more like assistants who must follow their orders — a belief not unlike that held in the United States many years ago.

“The nurses were very eager to move their profession forward and update their knowledge,” Jarrett said. “What we want…

Visit www.cdc.gov/actearly to download materials or request a FREE kit.

CDC has free information to help educate parents about childhood development.

Autism can often be recognized at 18 months or younger. The Centers for Disease Control and Prevention (CDC) has prepared materials to help health care professionals inform and educate parents about childhood development, including the early warning signs of autism and other developmental disabilities.

Visit www.cdc.gov/actearly to download materials or request a FREE kit.
ed to do is give them the help they needed in the beginning, so they could go on to create positive change in their profession and in patient outcomes.”

Collegiality and learning went both ways. “During that first trip, the nurses did anything they could to make us feel comfortable and welcomed,” Jarrett said. “And the longer we were there, the more open and candid they were about the stark reality of their working conditions. They also were very proud about the care they were able to give in spite of those conditions.”

When Jarrett and her fellow-Colorado nurses returned, they formed the Friendship Bridge Nurses Group. They then enlisted the help of about 25 nurse educators nationwide to teach a post-baccalaureate certificate program for nurses in Vietnam. The program was developed in collaboration with leaders in that Southeast nation so the coursework would meet educational and regulatory criteria, as well as nurses’ needs.

The nine-course program was launched in 1995 at the University of Medicine and Pharmacy in Ho Chi Minh City. Courses included advanced health assessment, nursing research, nursing leadership and community health. About 30 Vietnamese nurse educators and nurse administrators from provinces within the southern portion of Vietnam participated in the initial program over the course of about four years.

Over the next few years, the Nurses Group, which now has more than 60 nurse educator volunteers, offered the post-baccalaureate program in the northern part of Vietnam and again in the southern section. It then implemented a scholarship program to send Vietnamese nurses to Thailand to earn their master’s degrees. More recently, the Nurses Group and their Vietnamese colleagues developed a master’s program in nursing – the first ever in Vietnam – that earned government approval. Eight graduate students started the two-year program in September 2007.

The experience

Among the early volunteers was Behrens, who went to Vietnam in 1995 to help teach the first round of post-baccalaureate courses – specifically advanced health assessment. She came prepared, bringing her students current textbooks and stethoscopes – both rare commodities at the Vietnamese facility. (Nurses were accustomed to sharing one stethoscope for an entire unit.)

The first time I went there, the nurses sat very rigidly – taking notes and not asking any questions,” Behrens said. “It took some role modeling to get them to feel comfortable interacting more with me and working in small groups. But they were so anxious to learn, and they taught us how to do with so little.”

One example of nurses’ resource-saving is their ability to successfully perform sterile procedures using one glove, according to Behrens.

Behrens also was a little worried about whether the nurses would be able to practice their advanced skills in the clinical setting, because of the physician-dominated health care model. However, the Vietnamese nurses successfully completed their head-to-toe exams of patients, and the physicians seemed to accept – and respect – the nurses’ abilities.

Behrens said she would not have learned about the nurses’ hardship had it not been for an informal conversation the nurses had with her friend, who had accompanied her on this most recent trip and who was originally from Vietnam. Ultimately, Behrens helped the nurses learn how to more effectively scan documents to see whether they were useful and therefore needed to be printed.

In terms of the community projects, one group of graduate students chose to focus on improving dental care among school-aged children. The nurses’ resourcefulness led to them getting a model of a tooth and a large supply of toothbrushes donated from the Colgate Co. Another group tackled a project aimed at preventing type 2 diabetes, which is a growing problem in Vietnam caused by increased protein intake and – ironically — better nutrition.

Behrens and other volunteers leave medicine and toys for the roughly 200 children in an orphanage in Ho Chi Minh City.

Looking beyond the classroom, Behrens recalled also feeling somewhat frightened about how she as an American would be received in post-war Vietnam. But neither she nor any of the nurses traveling there ever encountered a problem.

Over the years, Behrens has taught many classes in Vietnam, including senior-level management, research and community health nursing. And this April, she worked with graduate nurses to help them complete their community health projects, assist them with their English skills and begin their research projects.

As often is the case, Behrens learns more about the nurses’ struggles and the unique health needs of the country’s population with each trip.

For example, Behrens recently discovered that although the nurses had access to 10 computers in their library, they had no available printer. So they had been downloading numerous research articles to memory sticks and then printing them out at a local photocopying shop. That practice was both costly and time-consuming.

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Jarrett also went back in June to work with the graduate students to develop their theses.

Looking back at her first trip to Vietnam, Jarrett recalls being asked by the nurses if she would ever come back; an ongoing partnership seemed like a lofty goal. But the program continues, although travel and other rising costs are an increasing concern.

“Except for a few small grants early on, it’s really been an all-volunteer project – all done from the heart,” she said.

Since 1995, the activities of the Nurses Group have been organized and directed by a three-person steering committee: Jarrett, Whitney and CNA colleague, Faye Hummel, PhD, RN, CTN. They are now exploring resources to help sustain the program and also hope to some day share the graduate model they developed with other Third World countries.

For more information on the Friendship Bridge Nurses Group, go to www.friendshipbridge.org.
Physicians were asked if they believe that universal health care insurance will significantly improve access to health care for all Americans. Their responses were quite polarized with 38.8 percent indicating no improvement while 33.8 percent feel that it would significantly improve access to health care. Just over 44 percent feel that there is no evidence to support that expanding insurance coverage is a cost-effective way to promote health.

Do they believe that health care insurance should be mandated for all Americans? Again, the group was split with 42.7 percent of responders for mandated coverage and 40.2 percent against such mandates. And when asked how a universal health care system should be funded, less than 10 percent feel it should be funded by the federal government, with nearly 60 percent preferring some combination of state, federal, employer and individual contributions.

This survey was conducted as an independent research study by DoctorDirectory.com, Inc., a marketing services company serving health care professionals and pharma industry clients. For more information about this study, go to www.doctordirectory.com.

New tool to help prevent med mix-ups

The U.S. Pharmacopeial (USP) Convention recently announced a new drug safety tool designed to help patients, caregivers, pharmacists, physicians and others in avoiding medication errors that may occur because of drug names that look alike or sound alike.

This "Drug Error Finder" is a searchable database of almost 1,500 commonly used drugs reported to be involved in medication mix-ups in the U.S. health care system since 2003. The database is available at no cost to www.usp.org/hqi/similarProducts/drugErrorFinderTool.html.

It is derived from a list of 1,470 unique drugs that were implicated in medication errors due to brand or generic drug names that look or sound alike and reported to USP’s MEDMARX®—an anonymous database used by hospitals and health care systems across the United States to report, track and analyze medication errors—or to USP’s Medication Errors Reporting Program. The list was included in USP’s 8th annual MEDMARX Data Report, released in January 2008, which examined more than 26,000 error records related to similar drug names submitted to the database from 2003 to 2006. This is the largest known list of look alike, sound alike drug names in the world based on actual medication error reports.

“As more medications are approved for market each year and become available to Americans, the opportunity for potentially dangerous or even deadly errors due to drug mix-ups from look alike or sound alike names becomes increasingly high,” said Diane Cousins, RPh, USP vice president of health care quality and information. “While one drug name may be nearly identical to that of another drug, the two could be used for completely different conditions. This presents a major public health threat, and we think this new tool can play an important role in helping to reduce patient risk associated with this problem.”

One example of a drug involved in such errors reported to MEDMARX is Clonidine, a high blood pressure medication. In actual instances reported to USP, this drug was confused with multiple drugs, including Colchicine (used for gout), Cetirizine (an antihistamine), and Clonazepam and its brand name, Klonopin (used for anxiety and seizures).

To use the Drug Error Finder, type in the name of the particular drug of interest. In addition to rapidly generating a list of medications that have been confused with that drug, the tool will also allow users to see the severity attributed to the reported errors involving the drug (ranging from Category A for “potential for error” to Category I for “death”).

The Drug Error Finder is one component of USP’s response to the Institute of Medicine’s 2006 report, Preventing Medication Errors, which calls on the government and public health organizations to address medication errors resulting from similar labeling and packaging, as well as confusingly similar drug names.

New master’s program to address nursing faculty shortage

The master’s program at The University of Texas at Arlington School of Nursing (UTASON) has added a master of science in nursing education program to not only answer the escalating nursing shortage in Texas and across the nation, but to also address a shortage of nursing faculty.

This new program prepares nurses to practice as nurse educators in schools of nursing and health care delivery systems. Emphasis is on the knowledge and skills needed to develop curricula, teaching skills, and evaluation strategies. Graduates will be eligible to take the National League for Nursing Certified Nurse Educator Examination following two or more years of full-time employment in the academic faculty role.

For more information, go to www.uta.edu/nursing.

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ANF 2008 NRRC chair defines leadership in the moment

By Holly Blackledge, Director, American Nurses Foundation

This past August, the American Nurses Foundation (ANF) awarded 30 Nursing Research Grants (NRGs) totaling $190,106. These grants ranged from $3,500 to $20,000, awarded by the 12 members of the ANF Nursing Research Review Committee (NRCC). The 2008 NRRC was chaired by Patricia Liehr, PhD, RN, who is serving her third and final year on the committee. Liehr joined the NRRC in 2006 and served as NRRC vice chair for 2007 and chair in 2008.

Liehr’s responsibilities focused on leading the NRRC forward not only in reviewing and awarding grants to the highest quality applicants, but also in ensuring the integrity of the overall process. She accomplished this with professional grace. On Aug. 25 and 26, the 2008 NRRC met by conference call to review the 114 applications ANF received for funding. After two days of focused review, the NRRC recommended to the ANF Board of Trustees that 30 grants be awarded to the nurse researchers whose studies met requirements for funding.

Along with NRRC Vice Chair Linda Chlan, PhD, RN, Liehr was applauded by the NRRC members for having steered the process well and for continuing to build the future of the NRG review process that transitioned to the conference call model in 2007. Truly, it was her own philosophy that summed up the success of this year’s process: “It served me well to stay in the present bringing all my attention to the discussion as it was occurring. It was hard to do but from that base, I was most able to know where I was standing so that I could extend to others and move the process along.”

Florida Atlantic University Christine E. Lynn College of Nursing is where Liehr serves as associate dean for nursing research and scholarship and professor. Her research focus includes exploring the importance of stories in nursing practice; capturing bodily experiences by real-time measures, such as ambulatory blood pressure; the links between stories and real time measures; and cultural perspectives that define one’s view of health.

Liehr is known for her middle range theory work and has recently co-edited the second edition of Middle Range Theory for Nursing with Mary Jane Smith, PhD, RN. Story theory, a middle range theory developed by Smith and Liehr, guides her practice and research. She has studied story as an intervention, story-centered care and story as an outcome measure using qualitative and quantitative analysis methods. She believes that stories are both powerful entities for chronicling and creating health, and for capturing substantive data guiding nursing practice.

One of Liehr’s currently active research endeavors is analysis of stories of health from Pearl Harbor and Hiroshima survivors to be developed as a youth-focused DVD, “Two Sides of the World War II Story: Surviving the Aggression of War.” Her decade-long research relationship with colleagues in Japan established a base for this cross-cultural analysis. Liehr has received many awards, including recognition as a Robert Wood Johnson scholar; an American Journal of Nursing book of the year award for the first edition of Middle Range Theory for Nursing; and selection as a visiting scholar to Tokyo Metropolitan Institute of Gerontology. In 2009, Chlan will step in as the NRRC chair with Patricia Pearce, PhD, MPH, FNP-BC, serving as vice chair. ANF wishes Liehr continued career success in nursing research and education.

Since 1955, the ANF, as the philanthropic arm of the ANA, has been in the business of promoting the welfare and well-being of nurses, advancing the nursing profession and enhancing the public health. This vital work is possible through the nurse researchers who proudly call themselves ANF Scholars. Over the past 53 years, ANF has awarded more than $4 million to more than 1,200 beginning and experienced nurse researchers. Many of these ANF Scholars have gone on to become leaders in nursing research, the profession and their own communities.

For more information on the ANF, visit www.ANFonline.org. ANF is a not-for-profit, 501(c)(3), organization. Donations are tax-deductible to the fullest extent allowed by law. Donations to ANF support the ANF Nursing Research Grants Program.

Obama

Continued from page 1

sponded, ‘Yes we can.’

“Nurses represent the largest group of health care professionals in this country, and working together, we can use our power in the voting booth to make health care a priority, and make Barack Obama the next president of the United States.”

Obama is committed to signing universal health legislation by the end of his first term in office that ensures that all Americans have high quality, affordable health care coverage. He recognizes that nurses play a critical role in every aspect of patient care, and the nursing shortage ranks as one of the most pressing issues facing the health care system. Obama’s health care plan includes expanded funding to improve the primary care and public health practitioner workforce, including loan repayments, improved reimbursement and training grants.

He has a history of advocacy for nurses and patients. In the Illinois Senate, he helped lead efforts to protect nurses and improve the quality of health care. In the U.S. Senate, he cosponsored the “Safe Nursing and Patient Care Act,” which limits mandatory overtime for nurses to true emergency situations. As president, he has promised to sign this important legislation into law.

ANA has been making presidential endorsements since 1984. The endorsement process includes sending a questionnaire on nursing and health care issues to all of the Democratic and Republican candidates, an invitation to all of the democratic and republican candidates for a personal interview and an online survey of ANA’s membership regarding which candidate is most supportive of nursing’s agenda. ■
Pandemic flu preparedness: working together to prepare now

The ANA is a proud supporter of the Take The Lead: Working Together to Prepare Nurses co-branded toolkit developed by the U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) along with input from community leaders. It is designed to provide nurses or their organization with key information and tools to help them understand the threat of a pandemic and prepare for it now.

The toolkit is available to ANA members at www.nursingworld.org/Home pageCategory/NursingInsider/Archive_1/2008N1/July08N1/CDCPandemicFluToolkit.aspx and provides the following:

• Information about pandemic flu
• Ready-to-use and ready-to-tailor resources prepared by HHS and CDC
• Ideas and materials to encourage organizations to prepare and to encourage other leaders to get involved
• Outreach materials such as sample newsletter articles and templates that can be tailored for activities Preparing for a pandemic influenza outbreak involves everybody. The threat of pandemic influenza is real, and America needs leadership from respected community members to prepare our towns and cities, reduce the impact of pandemic flu on individuals and families, and reduce or even prevent serious damage to the economy.

Pandemic preparedness efforts are an important part of community leadership. The ANA continues to represent nursing at many policymaking tables to discuss pandemic preparedness and the role of RNs in responding. ANA has been actively involved in policy discussions related to the prioritization of pandemic influenza vaccine; clarifying the level of respiratory protection necessary to protect health care professionals during a pandemic event; and identifying strategies for building surge capacity within the health care system to meet the significantly increased demand that a pandemic event would place on the system.

ANA has also partnered with the Trust For America’s Health to educate RNs about pandemic influenza and how it differs from the annual influenza season.

See Pandemic flu on page 14 ●

Chairperson of the Department of Nursing College of Nursing and Health Sciences

The Department of Nursing invites applicants for a tenured faculty member to serve as Department Chairperson, beginning fall 2009. Applicants must demonstrate excellence in teaching, an established program of research with external funding, and distinguished service to qualify for an appointment to the rank of associate or full professor with tenure.

The Chairperson must have significant administrative leadership experience, excellent communication skills, outstanding team building and collaboration skills, an understanding of higher education management policies and practices. Applicants must possess an earned doctorate in nursing or a related field and be eligible for RN licensure in Massachusetts.

Preference will be given to applicants with funded research and peer-reviewed publications focused on enhancing the health-related quality of life of urban populations of all ages and targeted to healthcare quality, health policy, and populations at risk for healthcare disparities. We are particularly interested in applicants who will strengthen our initiatives in cancer care, critical care, women’s health, physical activity and child health, healthcare quality or health policy, and who are committed to working with a diverse student population in an urban setting.

The College is committed to excellence in teaching and research and the Chairperson will have a significant role in ensuring these commitments continue to be met by members of the Department. The BS and MS nursing programs are accredited by the Commission on Collegiate Nursing Education. The MS and recently implemented Doctor of Nursing Practice programs focus on the preparation of nurse practitioners and acute/critical care clinical specialists. The PhD program focuses on the intersection of nursing and health policy. For more information, visit www.cnhs.umb.edu

To apply, please send a letter of interest and curriculum vitae to: Search #10194, Dr. Jacqueline Fawcett, Chair, Faculty Search Committee, College of Nursing and Health Sciences, University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125-3393.

The search will continue until the position is filled.

The University of Massachusetts Boston is an Affirmative Action, Equal Opportunity, Title IX employer.

Visit NursingWorld.org to see what’s new on nursing’s most popular Web site. Get up-to-the-minute nursing news, by nurses for nurses, by signing up to receive the ANA e-newsletter, NursingInsider, at NursingWorld.org/SpecialPages/NewsLetter/SignUpforANAcNewsletters.aspx.

As the Web Turns

This article describes research conducted to elicit faculty perceptions of facilitators and barriers for implementing a new, evidence-based, safe patient handling curriculum module at nursing schools.

A recently contributed article to the topic Nursing Shortage: Is This Cycle Different? is “Addressing Nurse-to-Nurse Bullying to Promote Nurse Retention,” by Carol F. Rocker, MHS, RN.

Another popular topic, The Multigenerational Workforce: Boomers and Xers and Nests, Oh MY!, also received a new article. “The Integration of Technology into Nursing Curricula: Supporting Faculty via the Technology Fellowship Program,” by Lawrette Axley, PhD, RN, CNE, describes a technology fellowship program designed to address the challenges facing faculty who did not “grow up” in the computer age.

Behaving badly

Continued from page 6

• Educate all health care team members about professional behavior, including training in basics, such as being courteous during telephone interactions, business etiquette and general people skills;

• Hold all team members accountable for modeling desirable behaviors, and enforce the code of conduct consistently and equitably;

• Establish a comprehensive approach to addressing intimidating and disruptive behaviors that includes a zero tolerance policy; strong involvement and support from physician leadership; reducing fears of retribution against those who report intimidating and disruptive behaviors; and empathizing with and apologizing to patients and families who are involved in or witness intimidating or disruptive behaviors;

• Determine how and when disciplinary actions should begin; and

• Develop a system to detect and receive reports of unprofessional behavior, and use non-confrontational interaction strategies to address intimidating and disruptive behaviors within the context of an organizational commitment to the health and well-being of all staff and patients.

When determining workplace actions that deal with bullying, however, care must be taken to not unwittingly escalate this behavior and drive it underground, Vessey noted. Colleagues who are being bullied, for example, may not want to put someone else’s position in jeopardy if a facility’s policy seems too rigid.

Felbinger recommended educational programs that utilize both case studies and role playing that can be accomplished through online and small group participation.

“For those programs, nurses also can learn how to deal with abusive situations — whether it’s something that is said or done under stress or not. We all should be able to give meaningful apologies where one offers regret, takes responsibility and offers a remedy to correct what’s occurred.”

“And a person getting an apology also has the option of accepting it or not.”

As for other policies that health care facilities develop as a result of Joint Commission alert, Felbinger said they must be practical, helpful and useful for nurses working at the bedside. And they must be measurable to ensure they are effective.

“We know there’s a problem,” Felbinger said. “We’ve looked at it enough. Now we need the interventions.”

Concluded Murray, every health care organization has a responsibility to its nurses to ensure that they all feel safe in their workplaces and feel safe to report an abusive act.

“The nursing shortage isn’t a good excuse for bad behavior,” he said. “We’re not doing our profession any good if we use that as an excuse.”

For more information on the alert, go to www.jointcommission.org. For more on AACN’s standards, go to www.aacn.org/hwe, and for more on strategies, see Murray’s article in the July issue of American Nurse Today.

Susan Trossman, RN, is the senior reporter for The American Nurse.
Count on it: Nurses’ votes matter

By Rachel Conant and Hilary Hansen
Senior Political Action Specialists

On Tuesday, Nov. 4, Americans will elect our next president of the United States. This will be a historic election on many levels – this is the first presidential race since 1952 in which neither an incumbent president nor incumbent vice president is on the ballot. This election is the first in history in which two sitting senators are running against each other. Further, in this presidential election, the winning party will have either an African American or a woman on the ticket.

The nation is captivated by what will no doubt be an exciting presidential election. But along with that historic racing, 435 U.S. House of Representatives seats and 33 Senate seats are up for election. Along with those congressional races, there will be 11 gubernatorial races across the country.

Sadly, you often hear people lament, “Why should I vote? My vote doesn’t count!” But think about this: During Alaska’s primary on Aug. 26, Rep. Don Young beat a challenger by a mere 145 votes out of the 84,000 cast. During the 2006 mid-term election, Rep. Rob Simmons (R-CT) lost his congressional seat by a mere 83 votes. Political experts think the general election in 2008 will be no exception to the recent tight races we’ve seen.

Despite the historical importance of the presidential election and the excitement of the congressional races, what excites ANA most about the 2008 election is that it’s another chance to bring pro-nursing advocates to Washington.

With recent elections being decided by a few hundred votes, it is imperative that ANA members are not only registered to vote, but that they actually do vote on Nov. 4. In fact, most states allow residents to vote early in the general election so they are not waiting in long lines on Election Day. Also, if you know that you will be traveling on or around Election Day, remember to fill out an absentee ballot. Check with your local election board to find out your state’s regulations.

There are other ways ANA members can get involved and make a difference in this year’s election – adopt a pro-nursing candidate. As a registered nurse in the community, it is crucial for you to learn about the candidates running for office in your district and where they stand on nursing issues. During the campaign season, there is no better time to research their positions on the issues and to start to build a relationship with them – especially if they are non-incumbents. ANA members helping to elect pro-nursing candidates to Congress is vital to ANA’s continued legislative success. If elected to Congress, ANA’s foot is already in the door, and we have a connection in the district – you.

Volunteer on a campaign on either a full-time or part-time basis. In this capacity, there are a myriad of projects that the campaign will need your help on. Walking around precincts to hand out literature, making phone calls around the district, helping with various events and town hall meetings, or providing assistance at the polls on Election Day are just a few things you can do based on your schedule.

By voting on Nov. 4, you could help bring pro-nurse advocates to Capitol Hill. Legislators elected in November will be confronted with a bevy of issues that affect not only nursing, but health care in general. Some of these issues include nurse staffing, education funding and health care reform. Without maximum voter turnout from ANA members, their friends, families, colleagues and even patients, it will be impossible to elect legislators who will pass nurse-friendly legislation in the upcoming 111th Congress.

Remember that every state has different voter registration deadlines. Also, many states allow residents to vote early. To find out more information about your state, visit http://www.canivote.org/. This nonpartisan Web site is run by the National Association of Secretaries of State. Let’s make nurses’ voices the difference in the mid-term elections. Volunteer for a campaign. Make sure friends, families and colleagues are registered to vote. Vote on Nov. 4.

CE Corner

Caring for Chronic Wounds: A Knowledge Update

Wound care is a lot more sophisticated than it used to be. Here’s what you should know about assessing and managing chronic wounds. Learn to:

• Explain the pathophysiology of atrial fibrillation (AF).
• Identify how to assess a patient for AF.
• Differentiate heart rate control and heart rhythm control in AF management.
• Discuss nursing interventions for patients with AF.

1.6 contact hours, including 0.5 pharmacology contact hours, are provided by ANA.

The American Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

ANA is approved by the California Board of Registered Nursing, provider number CEP6178.

New online CE available

Current Approaches to Managing Atrial Fibrillation

How up-to-date is your knowledge base? The most common sustained cardiac arrhythmia, atrial fibrillation (AF), is reaching epidemic proportions. No matter where you practice, you’re bound to care for patients with AF. Learn to:

• Explain the pathophysiology of atrial fibrillation (AF).
• Identify how to assess a patient for AF.
• Differentiate heart rate control and heart rhythm control in AF management.
• Discuss nursing interventions for patients with AF.

1.6 contact hours, including 0.5 pharmacology contact hours, are provided by ANA.

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REGISTERED NURSE (RN)

DO YOU WANT TO BE PART OF THE BEST?

JOIN OUR TEAM!!

The Paralyzed Veterans of America (PVA) is currently seeking a full-time Registered Nurse to be the Associate Director (RN) for our Medical Services Department in Washington, DC.

The successful candidate should have a minimum of two years experience working with spinal cord injury or dysfunction (SCI/D). Familiarity with the Department of Veterans Affairs’ organizational structure, case management techniques, and clinical record interpretation is desired. BSN, and/or management training is a plus. Applicant must be able to generate a professional site visit report. We offer a competitive salary, outstanding benefits, some travel, and a Monday thru Friday work week. Send resume with cover letter and salary requirements to: careers@pva.org or fax to (202) 416-7633. EOE.

PVA is a Washington, DC based non-profit veterans service organization dedicated to serving individuals with spinal cord injury/disease.
Global issues
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moting Chicken Little theories that are nothing more than fraudulent messianic faiths.

— Larry Clifford, RN
Member, Minnesota Nurses Association

Editor’s Note: At the 2008 HOD, delegates adopted a measure introduced by ANA and the Delaware Nurses Association to address the challenges associated with global climate change. ANA was asked to encourage constituent member associations to support local public policies that endorse sustainable energy sources to reduce greenhouse gas emissions, as well as initiatives to decrease the health care industry’s contribution to global climate change.

Response from Nancy Hughes, director of ANA’s Center for Occupational and Environmental Health:

Thank you for taking the time to express your opinion. I would like to address the concerns you recently sent to ANA about the issue of global climate change.

Because there are disease implications that will impact health care including nurses, ANA’s resolution was developed and was subsequently passed by the 2008 HOD. In life, we prepare for many events that may or may not happen, however using the best evidence at the time indicating a threat. ANA strives to provide information to the RNs about issues that impact their practice and public health. Hopefully the worst case scenarios will not come to pass. In the meantime, the global climate change resolution will help nurses be aware of the possibilities and also actions that can be taken to protect the environment for a healthy planet as it has been rooted in nursing history.

We would invite you to review ANA’s Environmental Principles for Nursing Practice with Implementation Strategies. There is much opportunity for nurses to positively impact the environment, such as being involved in an environmental task force at your state nurses association or on a green team at your workplace.

Consensus model for APRNs applauded

I want to personally thank ANA for its advancement of the APRN Model Act/ Rules and Regulations that recognizes the Consensus Model for APRN Regulation, Licensure, Accreditation, Certification and Education, which was endorsed by the ANA Board of Directors in June 2008. This is a wonderful achievement. I would also like to thank those individuals who were instrumental in the formulation and passage of this model. Their contribution to the advancement and future development of advanced practice nursing is very important.

I recently wrote a letter to the member of the Connecticut Society of Nurse Psychotherapists about the adoption of these policies as they pertain to psychiatric and mental health nursing practice and certification.

I attended the meeting held at the International Society of Psychiatric Nurses conference in the Spring of 2008 in Louisville, KY, attended by the board of directors of the International Society of Psychiatric-Mental Health Nurses, American Nurses Credentialing Center leaders, and many of the deans and chairs of psych nursing from schools of nursing across the U.S. that offer MSN programs in psychiatric nursing. In this meeting the issues of licensure of NPs and CNAs were discussed.

It should be noted that the MSN programs represented at this meeting offered multiple models of NP programs with differing preparations. The model of CNS programs from which many experienced MSNs in psych nursing graduated, to my knowledge, is no longer being offered. The new model of NP meets the growing need for nurses prepared to assess and treat individuals with chronic mental and physical illnesses.

The boundaries of these conditions are often blurred and require assessment by clinicians with a broader educational and clinical preparation than those of either traditional mental health or medical nursing practitioners.

Interview series
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Disease. Upcoming interviews are with the American Academy of Pediatrics, the American College of Cardiology, the American Hospital Association and the National Women’s Law Center.

Four highlight videos compiling leaders’ views on access to health care coverage, affordability, private vs. public plans and the potential for change from the first set of interviews in the series are also available.

The series covers a variety of health care issues, including covering the 47 million uninsured Americans, reducing health care costs, improving access to care, enhancing the quality of health care and changing the tax structure to allow more people to purchase their own insurance.

Webcasts and podcasts of the interviews and highlight videos can be accessed on health08.org and on the Foundation’s YouTube page.

Pandemic flu
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The ability of our current nursing education and practice leadership, ANCC, and National Council of State Boards of Nursing, to rapidly come to consensus in a remarkably short time and integrate the multiple currents of belief about “advanced practice mental health nursing practice” into an approach that meets the needs of patients — our ultimate goal, after all — is to be commended.

It is important to remember that the CNS role is being respected in the acceptance of the “new” psych/MH NP model. The CNS-prepared psych/MH practitioner will continue to be an important presence in the care of mentally compromised patients.

Another important issue addressed in this summary is the right of doctorally prepared NPs or CNAs to use the designation of doctor (Dr.) in their nursing practices, if they so choose. Currently, the American Medical Association is contesting this right, specifically for the doctorally prepared nurse.

On behalf of all CNS and NP-prepared psych/MH nurses, I want to thank the nursing leaders in the U.S. for their important work on this issue that will affect the care of mentally compromised patients for years to come.

— Pat D. Barry, PhD, APRN (ANCC P/MH board certified)
Health care highlighted in presidential campaigns

Health care professionals, interest groups and lobbyists are making an effort to ensure health care remains front and center in the presidential campaign. Modern Healthcare examined some of the groups making their presence felt at the two political conventions. Among them was ANA, which sent staff and a representative of its political action committee to both the Democratic and Republican conventions. “We believe health care and our issues are bipartisan issues,” Rose Gonzalez, MPS, RN, ANA’s director of government affairs, told Modern Healthcare. ANA also hosted a panel on health care reform with several other organizations. “Speak Out: If I had one minute with the next president” was attended by policy experts, health care professionals, industry leaders, celebrities and the media.

Nurse.com took a closer look at both candidates’ health care plan in their Sept. 8 piece, “Which Plan for America?” Cynthia Haney, JD, senior policy fellow at the ANA, weighed in, calling Barack Obama’s plan “most consistent with the American Nurses Association’s policy for healthcare reform” because it “guarantees high-quality affordable healthcare for all.”

The article mentioned that both candidates promise to bring health costs down and help pay for their plans by promoting increased competition among drug and health insurance companies and by investing in information technology, coordinated care and disease management, wellness and prevention programs, and health education starting at school levels. Both support mental health parity, a strong public health system, and making health care costs transparent.

The article stressed that while health care remains an issue during the campaign, how much reform actually occurs won’t be seen until weeks and months after the ballots are cast. The article went on to urge nurses to get involved in the process by working with state and local legislators on health care issues.

New York Times focuses on safety of nurses on the job

Workplace violence is on the rise, and health care professionals are at risk. A July 8 New York Times article examined the disturbing trend of workplace violence and what nurses are doing to protect themselves. According to the federal Bureau of Labor Statistics, half of all nonfatal injuries resulting from workplace assaults occur in health care and social service settings. Nurses and other personal care workers bear the brunt of such attacks, with 25 injuries annually resulting in days off from work for every 10,000 full-time workers — 12 times the rate of the overall private sector, according to the bureau.

Nancy Hughes, MS, RN, director of ANA’s Center for Occupational and Environmental Health (COEH), described her own experience with on-the-job violence when she was attacked in the emergency room by a patient high on drugs. She was hit in the back and had to require surgery. “It was quite a traumatic event, but I didn’t get much support where I worked,” she said. “The doctor I was working with said, ‘Don’t be a wimp,’ sort of take your lumps and don’t worry about it.”

Some states are considering legislative fixes. Last year New Jersey and Oregon passed legislation that requires health care facilities to assess the dangers of workplace assault and develop programs to address it. Many nursing organizations argue that staffing levels could also be a solution to reducing violence.

Congress overturns presidential veto; passes Medicare legislation

The “Medicare Improvements for Patients and Providers Act” (H.R. 6331) received overwhelming support in the House, and in a Sept. 8 article, “Smart Move,” the Tennessee Commercial Appeal examined the trend of safe lifting equipment. Nancy Hughes, MS, RN, director of ANA’s COEH, said ceiling lifts are comfortable for patients and easier for staff than other mechanical devices. “They’re the best,” she said.

The article cites several factors in the need for lifting equipment: the aging U.S. populations mean hospitalized patients are sicker and more likely to need assistance to move, the nursing population is aging, and rising obesity rates mean that health care professionals are moving heavier people.

The article references the Bureau of Labor Statistics, which shows that registered nurses, nursing aides, orderlies and attendants are among the occupations at the greatest risk for on-the-job strains and sprains.

Lawmakers examine nursing shortage

When the House Judiciary Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law held hearings on the need for work visas for highly skilled workers, they called upon the ANA for its perspective.

Nursing Spectrum covered the hearings, where ANA’s new director for practice and policy, Cheryl Peterson, MSN, RN, spoke. “It is inappropriate to look overseas for nursing workforce relief when the real problem is the fact that Congress does not provide sufficient funding for domestic schools of nursing; the U.S. health care industry has failed to maintain a work environment that retains experienced U.S. nurses; and the U.S. government does not engage in active health workforce planning to build a sustainable nursing and health professions workforce for the future.”

Peterson also said, “Over-reliance on foreign-educated nurses by the health care industry serves only to postpone efforts to address the needs of nursing students and the U.S. nursing workforce.” She noted that last year the federal Nurse Education Loan Repayment Program turned away 93 percent of applicants, and the Nursing Scholarship Program denied 96 percent of applicants.

Keeping patients and nurses healthy

At hospitals across the country, nurses are leading the way in bringing lifting equipment to hospitals. It ensures patients are lifted safely, and nurses and other health care professionals have less risk of on the job injury. In a Sept. 4 article, “Smart Move,” the Tennessee Commercial Appeal examined the trend of safe lifting equipment. Nancy Hughes, MS, RN, director of ANA’s COEH, said ceiling lifts are comfortable for patients and easier for staff than other mechanical devices. “They’re the best,” she said.

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ANA’s Safe Staffing Campaign

The American Nurse is the official newspaper representing the nation’s registered nurse population with a circulation of 157,000 nurse members of the American Nurses Association. In addition, 26% of its readers pass it along to other nurse colleagues. Its readers are qualified, professional and influential nurses who are on the forefront of health care. This market has the purchasing power to make buying decisions. That’s one of the reasons they read The American Nurse!


Media Briefs

During ANA’s 2008 biennial House of Delegates meeting in Washington the week of June 23, ANA placed this advertisement at the Dupont Circle Metro station to bring attention to ANA’s Safe Staffing Campaign.
ANA is excited to announce the NEW Nurse’s Career Center, your convenient connection to over 10,000 new job opportunities targeted to clinical nurses. Don’t waste time wading through job postings that do not match your skills. The NEW ANA Nurse’s Career Center includes only those jobs that matter most to you – clinical nursing positions.

Visit the ANA’s new Nurse’s Career Center and experience the advanced features and benefits:

- **Personal Profile Page:**
  Create your own security protected site complete with URL.

- **Résumé Wizard:**
  Upload or create multiple résumés and make them searchable and visible to top employers.

- **Job search:**
  Free, fast, confidential access to a credible selection of targeted employer opportunities.

Search nursing jobs in your neighborhood or across the country at this one-stop resource for quality registered nurses.

Find a NEW world of opportunities at [www.nursescareercenter.com](http://www.nursescareercenter.com)

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