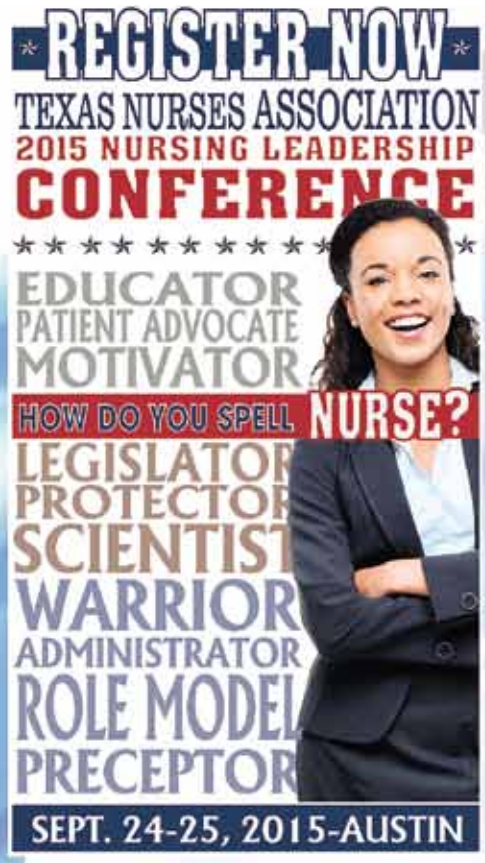

MORE INFORMATION INSIDE!

A TNA NEWS PUBLICATION FOR ALL NURSING PROFESSIONALS

TEXAS NURSES ASSOCIATION

TEXAS NURSING VOICE

texasnurses.org Volume 9 | Number 3 | July, August, September 2015

Quarterly publication direct mailed to approximately 250,000 RNs and Advanced Practice Nurses in Texas.

Texas Legislature Wraps-Up 84th Session

Andrew Cates, Texas Nurses Association

After 140 days of what to the untrained eye appears to be complete chaos, the Texas Legislature has concluded the business of the 84th session. The **Texas Nurses Association** was active throughout, working to ensure that you and your patients are protected. TNA is proud to represent Texas nurses, and the government affairs staff looks forward to working throughout the next 18 months preparing for the 2017 session!

Special thanks to the hundreds of Texas nurses who attended Nurse Day at the Capitol, visited legislative offices, and wrote or called your legislator. Your efforts made a huge difference!

The 2015 legislative session was significant for many reasons, most notably because it was the first session after Gov. Rick Perry left office. The impact of his departure was a reshuffling of offices—all major statewide offices changed hands as elected officials traded up, with the dominoes falling through the Senate and House as well.

When the smoke cleared, the legislature looked like this:

House – 19% freshman
Republicans – 98 seats out of 150
Democrats – 52 seats out of 150

Senate – 35% freshman
Republicans – 20 seats out of 31
Democrats – 11 seats out of 31

What did this mean for TNA and the nursing agenda? We had to do significantly more education on nursing issues for legislators who were not aware of the problems out there!

Here are the final numbers for this session (pending Governor veto):

6,276 bills filed –	7% increase from the 2013 session
1,323 bills passed –	8% decrease from the 2013 session
21% passage rate	

TNA worked overtime to ensure that elected officials could filter through the noise and understand the nursing issues that were front and center.

Physician Complaint Confidentiality

One of the biggest and most dangerous issues that TNA worked on this session to protect your rights had to do with physician complaints. Multiple bills this session tried to undo years of whistleblower protection afforded to nurses who file complaints against physicians that act unprofessionally. Each of the bills would have required the Texas Medical Board to provide a copy of the complaint (either thinly redacted, or not redacted at all) to the physician. Supporters said that the bill would provide the physician the constitutional right to "face his accuser."

However, TNA and thousands of nurses across the state know better. If the court case and subsequent career-ruining publicity of the Winkler County case from 2003 is any indication, these bills only would have allowed physicians to retaliate against those who report them. The Winkler County case was against two nurses who fulfilled their ethical duty to report a misbehaving physician and as a result were fired and indicted on trumped up charges which they later prevailed against.

TNA takes these threats to nursing very seriously and fought hard against the bills. In fact, after TNA solicited calls to action to our membership, members of the legislature received more than 1,000 emails and phone calls on these bills alone! TNA Government Affairs staff was told at one point, "I hear the nurses are firebombing the capitol over this complaint bill!" And firebomb it, we did. TNA spoke with every member of the Senate to defend each and every nurse in Texas against possible retaliation, and at the end of the day, we won!

TNA successfully ensured that the Senate knew where nurses stood, and the bill never made it out of the Senate. Another bill in the House died on the Local and Consent Calendar after we similarly defended in that chamber. TNA works hard for every nurse in Texas on hundreds of bills just like these. Please support TNA and join as a member if you are not already, to add your voice to those protecting nursing against attacks like these in the future!

To find out more about the other major and most directly influential nursing bills that TNA worked on this session on behalf of nurses, visit the TNA website at *texasnurses.org*.

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A Case for Concept-Based Nursing Education

Susan England PhD RN, Clinical Associate Professor, Texas State University; Lolly Lockhart PhD, RN, Health Care and Nursing Education Consultant, and Ellarene Sanders PhD, RN, NEA-BC, Nurse Consultant

This article focuses on the need for concept-based nursing education and the development of model courses to be utilized by nursing programs in Texas. As most faculty and nursing students can tell us, it is challenging to cover everything in a systems-based curriculum. Every new development leads to addition of content in the curriculum. Some describe this literally as content saturation or content explosion. Clinical experiences and learning opportunities vary widely according to the size and location of the clinical facility. A concept-based approach allows faculty to provide options for students to learn concepts and apply them in multiple clinical and case study scenarios rather than be exposed to every possible content variation.

To quote the original Academic Progression in Nursing (APIN) grant application, "In response to the shortage of nurses in Texas and the Institute of Medicine recommendation that by 2020, 80% of the nurses in the country should hold a BSN, the 2012 TNA Education Committee developed an organizing framework to drive strategies to increase the number of RNs who hold a BSN in Texas. The framework included three strategies to accomplish this goal: 1) Expand direct BSN production, 2) Increase concurrent ADN/BSN enrollments, and 3) Expand current RN to BSN programs and add new ones."

The third part of the framework is where the grant incorporated the work on concept-based curricula. This part of the structure of the 2012-14 APIN grant involved development and implementation of an optional, statewide concept-based curriculum, designed to facilitate the RN's progression toward a BSN or MSN. The expansion of this type of curriculum has the potential to further increase RN to BSN graduates.

Work for associate degree curricula was done prior to the APIN grant through Texas Concept Based Curriculum (CBC) project with funds provided by a Perkins Leadership Grant and Nursing Innovation Grant from the Texas Higher Education Coordinating Board. This work resulted in a total of six ADN programs adopting the CBC curriculum beginning in 2013, expanding to 14 by the fall of 2015. Use of this approach reduced the total credit hours in the ADN programs, allowing students to save money on tuition and fees and to have financial aid resources available to them for progression into BSN and MSN programs. Previously, students had often exhausted their financial aid in completing ADN programs.

Definitions

As defined by the Merriam-Webster dictionary (2015), a *concept* is an abstract idea, or a general notion, which when combined can form a group or class. When concepts are presented to learners, a range of information is made available, which allows acknowledgement of similarities and differences within each concept. In this way, the pertinent information can be gleaned and knowledge applied without needing to know all of the details.

For many years, nursing education has been based on the systems approach. This included pathophysiology of disease processes, signs, symptoms, and the nursing process. Learners memorized information to demonstrate understanding. Remembering and understanding are basic knowledge levels of Bloom's taxonomy (2015). Learners need to advance to application and analysis and can do this through the use of concept-based approaches. By using concepts, learners can group material in coherent ways, apply new knowledge within the frame of the concept, and analyze this information in present and future applications.

Concept-based curriculum

The development of concept-based curriculum takes into account meeting accreditation standards, Board of Nursing (BON) requirements, Institute of Medicine (IOM) findings, and Quality and Safety Education for Nurses (QSEN) competencies. Concepts included in the curriculum address student, course, and program outcomes. From the Texas Concept Based Curriculum project, a list of 43 healthcare and professional nursing concepts and definitions were developed for inclusion in the curriculum. The APIN grant expanded use of these concepts into RN-to-BSN and MSN courses. Detailed concept-analysis diagrams are available for deep learning about each of the concepts.

Exemplars are used to explain and apply concepts. These are examples of ideas, notions, or cases, which learners rely on when information is presented. Exemplars enable learners to associate information presented to gain broader understanding. These are the links that connect learning to real-life situations. When these connections are formed, learning is retained and becomes retrievable and

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applicable. Exemplars are an excellent means of presenting course content, and thus creating a broad, cohesive grouping of information, which can in turn be applied to a variety of scenarios.

When assigning concepts across curricula, some will only need to be included once, while others will progress, changing and advancing the exemplars each semester. For example, with the Nursing Innovation Grant (NIG), *diversity* was a one-semester concept with exemplars, which included: Hispanic traditions: curandero; Native American traditions: herbs, sweat lodges, healers; Jehovah's Witnesses and use of blood products; complementary and alternative treatments; spirituality; and sexual orientation: gay, lesbian, transsexual, and bisexual. *Ethics and Legal Precepts*, on the other hand, spanned four semesters with the exemplars beginning with criminal law, civil law, and American Nurses Association Code of Ethics and advancing to whistle blowing, Safe Harbor, obligation to report, risk management, and advance directives. Each of the courses in the ADN-to-BSN curricula have been placed on a curriculum matrix to crosswalk the outcomes with the Commission on Collegiate Nursing Education Baccalaureate Essentials (CCNE), BON Differentiated Educational Competencies (DECs), QSEN competencies for BSN, and the QSEN and CCNE Masters Essentials for MSN.

Concept-based teaching

Learning styles vary, but when learners can engage in the experience, participate in class discussions and activities, and relate content to previous learning, enrichment is achieved. Teaching strategies should include a variety of interactive methods in didactic and practice settings, which enables learner participation.

To advance conceptual thinking to clinical judgment, unfolding case studies, concept maps, care plans, and electronic health records may be used in the classroom so learners can explore concepts and their associated exemplars. As closely as possible, this needs to mimic the clinical setting. Learners can give hand-off reports to others in the class, using S-BAR (situation, background, assessment, and recommendations). This allows the learner an opportunity to utilize the nursing process, interact to enhance learning, and receive feedback. Bristol (2013) suggests using a 2+2 self-critique, where learners use a discussion forum to complete self-evaluations, which include 2 strengths and 2 areas for growth.

Continuity across the curriculum is important to enhance learner success. Faculty need to work together to use unfolding case studies that are similar in format and may even be the same client who was used in a previous semester but is appearing, perhaps more complex in the subsequent coursework. Evaluation tools and concept mapping need consistency as well so that learners do not need to start over with new templates each semester.

Barriers and incentives to transitioning to concept-based

Transitioning from content-intensive curricula to concept-based is not an easy process. Many current faculty have years of experience with traditional approaches based on the systems model. Making major curriculum and teaching strategy changes is never easy. For example, as simulation became more common in schools of nursing, some traditionally experienced faculty stepped aside rather than learn new approaches to teaching. Will this be an issue as we move into concept-based teaching? Can we retain our current faculty as we make the transition?

To address this issue, the APIN program, in concert with Elsevier, created webinars for faculty addressing the concept-based strategies and resources. These webinars are located at *www.texasapin.org*. Other continuing education offerings are available as well. Perhaps most important is faculty supporting one another as they address the need and process for change. Faculty in-service and sharing of ideas for adapting courses to concept-based can be a satisfying and creative process.

A second issue is the matter that most nursing textbooks are based on the systems model, although more of the current texts also address concepts. The issue is to identify the concept-based information and adapt it to the classroom and learning experiences. Undoubtedly as concept-based is used more often, textbooks addressing this need will be developed based on the demand. The bibliography for this article lists numerous resources to assist faculty.

Recent nursing graduates who experienced creative and innovative teaching strategies as students, such as simulation, may be more inclined to less traditional approaches to teaching and therefore, more accepting to concept-based teaching. These newer nurses need to be encouraged to prepare themselves at the master and doctoral levels for faculty positions.

The challenge of transitioning to concept-based for students is noted. Often students pursue learning by "memorizing and reciting" content to prepare for exams. More recently some faculty adapted their teaching strategy by "flipping the classroom" to prepare students prior to class, then engaging them in critical reasoning and application in class. This teaching strategy is ideally designed for teaching concept-based curriculum. Faculty who practice such approaches are able to mentor other faculty to follow suit.

What some may identify as potential losses in the transition to concept-based may in fact be advantages and opportunities for growth. Change is not always easy as there is a comfort level in the familiar. Faculty must change their course outlines, class materials, and resources to adapt to concepts. Faculty must locate or create materials to support their new approaches. There may be fear that the students will not be getting "all that they need" as identified in the traditional content-concentrated approach. Faculty may be unnecessarily concerned about potential changes in the NCLEX scores that have been successful with the traditional curriculum.

The benefits for a program to transition to concept-based teaching are many. First, the content in concept-based format is more reasonable in volume for the class time available. Second, faculty identify concepts that are progressed and adapted throughout the curriculum to build on the increasing complexity of clinical situations. Third, students are better prepared for critical reasoning and able to transfer learning to new situations. Fourth, the concept-based approach better prepares the graduates for the ever-changing world where knowledge and evidenced-based practice are constantly changing. Fifth, although not necessarily the last, the transition to concept-based learning provides an opportunity for faculty to be innovators and front-runners with the evolutionary changes in nursing education proposed in The Future of Nursing (IOM, 2011).

Faculty from schools across the state of Texas participated in the course development using templates. Individual faculty with content/concept expertise wrote course descriptions and course syllabi for each of the RN-BSN and MSN core courses. After the original development work, a team of three nurse educators edited and revised the course descriptions and syllabi for consistency, identified exemplars for the concepts within each course, and assured that the BON DECS, QSEN, and AACN-CCNE standards for BSN courses, and QSEN and AACN-CCNE standards for MSN courses were integrated. The syllabi are based on a 16-week semester but may be adapted to other time periods and adapted to the classroom or online. The courses and supporting tables are available at ecourses.tvcc.edu. (Unique login and password are required. If interested, send an email requesting login and password to *APIN@texasnurses.org*.)

RN BSN Courses	MSN Courses
Transition to Baccalaureate Roles	Advanced Health Assessment
Foundations of Comprehensive Health Assessment	Advanced Pathophysiology
Introduction to Nursing Research	Advanced Pharmacology
Leadership Roles and Management Functions	Role of the Advanced Practice Nurse (Education, Admin and direct care)
Population Focused (Community Health)	Population Focus
Foundations of Comprehensive Pathophysiology in Nursing	Research (Translational Inquiry)
Health Care Organizations and Informatics	Theory and Concepts
Ethics and Health Care Policy	Ethics and Health Care Policy
	Informatics

Using the concept-based course materials

The first step to consider in transitioning to concept-based is to secure faculty buy-in. Faculty must share information and approaches concerning what is needed and what is possible for their programs. Ultimately then, they must accept that changing times demand changes and that the concept-based approach is a recognized as a feasible prospect. Faculty buy-in is a process that needs exploration; including sharing and mentoring one another and recognizing that the changes are beneficial to the program, the students, and to the patients for whom nurses care.

Once the faculty makes the decision to transition to concept-based, the APIN proposed syllabi are considered. The faculty then determines how the transition can best be achieved in their situation. A timeline for preparing for the transition includes faculty exploration and education on the teaching strategies and concepts. One approach is to take the current courses and identify how each can be transitioned to one of the APIN proposed courses. As curriculum changes go, the first semester is the first to be transitioned to the new format, so the whole curriculum is not changed overnight, rather over the course of the program. The timeline can be used to monitor progress, course by course and semester by semester toward full concept-based. The use of standardized testing during the program continues to monitor student

learning and application of the concepts to clinical situations.

Evaluation of the impact of the transition

The American Association of Colleges of Nursing (AACN) (2015) reports there are 679 RN-to-BSN and 209 RN-to-MSN programs nationwide, and many of these are online. Enrollment in RN-to-BSN programs has increased steadily for the past 12 years. These one- to two-year programs build on existing knowledge, while preparing nurses for a higher level and broader scope of practice, thus allowing nurses to advance in their careers (AACN, 2015).

Measures of success

ADNs enter BSN programs with knowledge obtained from previous education, progressing from novice to competent or expert (Benner, 1984). Their previous practice influences performance when they enter the RN-to-BSN program, but they return as a novice or advanced beginner when introduced to new educational material (Sportsman, 2015). Building on this foundation allows for a wide-ranging scope of practice, including leadership, management, cultural competencies and diversity, community and public health, policy development, research, theoretical concepts, as well as economic, social, and professional issues affecting clients and healthcare delivery (AACN, 2015). Historically, ADN/diploma nurses returned to school a decade or more after becoming licensed. Of interest is that, in recent years, the trend is moving toward ADNs returning to school soon after graduation, rather than waiting. Since the learners are non-traditional, the curricula need to be learner-centered with faculty facilitating learner engagement. It is imperative duplication of content in BSN curricula is reduced or eliminated.

Student satisfaction

In a study reported by Allen and Armstrong (2013), ADNs reported several factors that prevented them from returning for a BSN. These included: cost, lack of time, fear of failure, lack of acknowledgment of previous educational and life accomplishments, and negative experiences from previous nursing programs. To reduce barriers, on-line and other flexible programs enable the return to education by eliminating or reducing scheduling or geographic accessibility issues. These programs also enable full-time ADNs to continue working full-time. On a positive note, there is an increase in diversity as more minorities are returning to school, and enrollment, retention, and graduation is increased. Additionally, 60% of these learners continue after graduation to pursue master's degrees (Allen & Armstrong, 2013).

As non-traditional learners, ADNs are self-directed, rely on previous life experiences, incorporate knowledge gained to problem-solve, and enjoy interactions with peers and faculty. ADN-to-BSN and MSN curricula incorporate relevant, available, and shared learning to address the learning styles and acknowledge the experiences of nurses returning for their BSNs and MSNs. Most of these learners are comfortable with computer and digital technology, such as cell phones, texting, social media, Internet searches, and video cameras. They are more likely to be successful if faculty engages and encourages group participation, and uses multi-tasking with immediate responses to interactive learning. This group likes 24/7 access to learning, which makes on-line courses preferable.

Faculty satisfaction

The current concept-based curricula are developed to ease the transition from ADN-to-BSN and MSN programs. The different teaching strategies can be both challenging and satisfying for faculty. As returning learners entering ADN-to-BSN programs, ADNs are self-motivated, apply previous life experiences and new knowledge to patient care, and enjoy connections made with faculty and peers, which facilitates the transition for faculty into ADN-to-BSN programs (Allen & Armstrong, 2013). These learners are more confident and are not afraid to question faculty about grades. They want to know why the material is taught, while still being nurtured and supported by faculty. Creative faculty utilize reflection, concept mapping, and questioning to develop critical thinking skills. Individualized clinical assignments incorporate learner's previous experiences; while on-line chats and discussions, which can be synchronous or asynchronous, facilitate anytime/anywhere learning. Faculty find that relevant assignments enable learner's socialization and change in professional values, attitudes, and roles to transition to develop new practice theories. On-line discussions, virtual worlds, and gaming may be offered to meet the learning styles of this group. Finally, the new approaches can be a benefit to faculty advancement and satisfaction.

NCLEX scores

In a white paper by Sportsman, a survey revealed that 30% of respondents reported an increase in NCLEX pass rates with concept-based curricula, while 42% reported there was no change and 5% reported lower pass rates. While that reduces the concern about NCLEX scores, further analysis is necessary in the evaluation of concept-based curriculum.

The next steps

School of nursing faculty are encouraged to explore the possibilities of concept-based curricula presented in this article and other references and be open to consider the opportunities to advance nursing education.

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The Role of the Manager

The fourth editorial in a series by Judith "Ski" Lower, MSN, RN, CCRN

Managers are in an ideal position to facilitate both the creation and maintenance of an environment of civility. Why? As front line manager, they know their staff — their needs, concerns, history, frustrations, relationships, and the stresses of their jobs. Managers are familiar with the hospital and human resources (HR) policies and expectations and have the authority to institute corrective action when needed. In addition, managers can be instrumental in building and maintaining an environment of clear behavioral expectations, including providing accountability, giving praise, and defining consequences. Consistent actions in these areas will establish a culture of civility on the unit/department. And ultimately, staff *expects* managers to deal with disruptive, uncivil staff.

Who are these perpetrators of incivility?

Understand that it can be anyone at anytime, given the right set of circumstances. The label can apply to staff seen as difficult, disruptive, bullies, passive aggressive, "pot stirrers," or "Queen Bees."

- Roughly one-third of these folks have no idea their behavior is problematic and will benefit from manager assistance.
- Another one-third know there is a problem but are not sure how to fix it and will also benefit from manager assistance.
- However, one-third KNOWS they are problematic and almost delights in it, frequently "daring" the manager to address it. Members of this category will often recruit the physicians to intervene on their behalf.

These behaviors are more often seen in the older generation of nurses who are clinical experts, highly valued for these clinical skills by both peers and physicians. Because these behaviors can impact patient safety, retention and recruitment, productivity, and unit reputations, they must be addressed, but due to a variety of barriers often are not.

Common barriers

What barriers exist to some degree for almost every manager?

1. **Feeling overwhelmed** – The task may seem overwhelming, especially when dealing with an employee who has behaved this way for a long time and has gotten away with it (for months or even years).
2. **No time** – With so many daily responsibilities and "fires" to put out, a manager may feel like there's no time to address the behavior. Even when initially addressed, there may be little time for follow up.
3. **No UNIT standards** – The unit may not have clear, established, or well-communicated standards for behavior. If staff feel they had little input into the development of unit standards and do not agree with them, staff may not support the manager's efforts.
4. **Inadequate training** – The manager may lack the training or experience to confidently address the behavior issues.
5. **Lack of support from "higher ups"** – There may be concerns that the manager's supervisor or HR will not provide support during the process or in the end when tough decisions must be made.
6. **Fear of retaliation** – The manager may fear retaliation from the offender, the staff, or even the physicians.
7. **Insufficient tools** – The tools utilized by the institution may not allow the free flow information for maximum benefit. The typical generic check off boxes with numbers rarely assist the employee in "getting it."
8. **Mental excuses** – Seemingly "good" excuses can affect one's ability to make a sound decision: "But she is so good clinically and works permanent nights." "She has been here for 25 years and is retiring in 18 months." or "We are short staffed; I can't fire her now."

Important points to remember

1. Tolerance only escalates the problem. The employee sees your inactivity as justification and support, while the "victim" feels unsupported and may leave or transfer off your unit.
2. Remember who is ultimately responsible for the uncivil employee's behavior. The answer is the employee, period. You can provide support and assistance, but the final outcome is theirs to own.
3. Think through the 'worst case scenario" and begin planning for preventative or defensive measures. Acknowledge it and address it lest it stops you from doing what you want/need to do.
4. Despite many complaints and requests for you to "do something," when you actually begin doing it the staff are usually silent, offer you little support, and don't admit their part in a resolution. This is fear and it will disappear once the employee's behavior or the employee is gone. *Then* they will thank you.

Some homework and preparation

1. Be informed. Refresh your knowledge of all hospital and HR policies related to this topic (code of conduct, discipline, lateness/absenteeism, creating a hostile work environment, etc.). It is also very important to make sure you have all the required documentation.
2. Get support and assistance **before** you begin. Make an appointment with your supervisor and HR to discuss the issue along with your goals and process. Seek their assistance, suggestions, and support; they can be your "BFF" in this.
3. "KYBI" (Keep Your Boss Informed). Update your boss frequently; keep them in the loop so they can continue to support your actions.
4. Know the employee's history. Pull and read all files. Identify what issues were raised, what behavioral patterns can be found, what performance plan was developed,

what follow up occurred, and what progress was made. Check the final outcome; were the goals met or not met? You may be surprised at what you do/do not find.

5. Review the hospital's appraisal and performance plan tools so you know how to maximize the information to be succinct and crystal clear. The typical generic "check a box and add up the numbers" rarely is helpful to an employee sincerely interested in change.

What can we do right now?

Cultivate the habit of being visible and available. Return to the MBWA (manage by walking around) philosophy. Reward and recognize good behavior as a matter of routine and advertise it. Staff needs to see and hear a new model of behavior. Talk up civility at every opportunity

Suggested blueprint to begin

Begin a unit civility project. Initiate discussion on civility and the consequences of uncivil behavior. You can research the topic yourself or get three to five strong informal or formal leaders to gather the information and present it with you to the staff. Hold staff meetings and focus groups to discuss the findings.

Survey the staff on what behaviors they find most disruptive and would like to see addressed. HINT: No names and no labels. Ask them to describe the behavior or "paint a picture with their words."

Share the list and comments with the staff. Then ask them to select the top five to work on as a unit for three months. They might not pick your top five, but they will be more apt to work on issues that are *their* top priority. Post the top five and solicit feedback from the staff. Ask the staff to begin self monitoring their own behavior, letting them know that violators of several of the chosen behaviors will meet with the manager. In one month (or whenever you choose), these will become the standard of behavior on that unit.

Meanwhile, you should have a good idea of who your top three disruptive employees are. Call them in individually and address the issues. **Important**: The goal is not to get rid of them. Rather, the goal is to make them aware of their behaviors and the impact on others as well as provide them with ways to react differently. Stress that you are giving them a heads up — advanced notice and a few weeks to begin those corrections before they become the unit standard, at which point consistent violations will have disciplinary consequences. Stress your desire to continue employing them, but with different behaviors. It is important at this time to create a specific performance plan.

What to say in that meeting, how to respond to the typical reaction of the staff nurse, FAQs, and helpful hints will be reviewed in part five of this series (to be published in the next Texas Nursing Voice). Samples of a performance plan will also be included the final part of this series.

What are the goals of this process?

- To create a healthy work environment by taking ownership of the unit and its behaviors;
- To clearly identify what is and is not acceptable behavior;
- To hold each other accountable; and
- To bring the uncivil employee with great clinical skills back into the fold but with different behaviors.

In addition, it is also to allow the manager to begin dealing with issues other than behaviors, like developing "up and coming staff" and stretching those more senior nurses.

Please tell me it is worth it!

Absolutely it is. By setting a new standard and holding people accountable, you will see a change on the unit: increased productivity, less gossiping, a "nicer" place to work, and increased patient safety, retention, and even recruitment. Research shows that in terms of increased productivity, getting just one disruptive staff member under control is the equivalent of hiring ***two*** FTE's without actually doing so. And finally, the staff *expects* the manager to deal with these folks so increased credibility and respect is also an outcome.

Coming in #5 of this series: Samples of staff-generated Unit Based Codes of Conduct, Counseling the disruptive employee: how to, what to say, responding to their excuses, FAQs, and some sample of performance plans.

Institute of Medicine to Become National Academy of Medicine

Recently at the 152nd annual meeting, the membership of the National Academy of Sciences (NAS) voted to change the name of the Institute of Medicine (IOM) to the National Academy of Medicine (NAM), effective July 1, 2015. The newly-named National Academy of Medicine will continue to be an honorific society and will inherit the more than 1,900 current elected members and foreign associates of the IOM. The National Academy of Medicine will join the National Academy of Sciences and National Academy of Engineering (NAE) in advising the nation on matters of science, technology, and health.

This change is part of a broader internal reorganization to more effectively integrate the work of the National Academies of Sciences, Engineering, and Medicine. Reports and studies on health and medicine will continue uninterrupted as activities of the Institute of Medicine, which will become one of the six program units operating under the direction of the integrated academies.

"The establishment of the National Academy of Medicine is a significant milestone in our history," said National Academy of Sciences President Ralph J. Cicerone.

"It is an acknowledgement of the importance of medicine and related health sciences to today's global research enterprise. It will also better align us to take a more integrated, multidisciplinary approach to our work, reflecting how science is best done today."

"Today, science, engineering, and medicine share many common areas of interest in the pursuit of discoveries, advancing knowledge, and solving problems of people and society," added National Academy of Engineering President C.D. "Dan" Mote Jr. "Having three national academies under one roof shows the ongoing collaboration among the people who are tackling today's grand challenges."

"This is indeed a momentous occasion," said Institute of Medicine President Victor J. Dzau, who will be the first president of the National Academy of Medicine.

"This change recognizes the important achievements of medical and health researchers, clinicians, and policymakers in improving health and medicine both nationally and globally," said Dzau. "We look forward to expanding our work together with the other Academies, and I am confident that this development will enhance our ability to provide evidence-based advice aimed at improving the lives of people everywhere."

The National Academy of Sciences was founded in 1863 under a congressional charter signed by President Lincoln, which created a body that would operate outside of government to advise the nation "whenever called upon." The National Academy of Engineering was founded in 1964. The Institute of Medicine was established as the health arm of the NAS in 1970.

TEXAS NURSES ASSOCIATION
2015 NURSING LEADERSHIP CONFERENCE

HOW DO YOU SPELL NURSE?

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ADMINISTRATOR
EXECUTIVE
LEGISLATOR
MENTOR

COORDINATOR OF CARE
CNO
LEADER
SCIENTIST
MANAGER
PATIENT ADVOCATE
PROTECTOR
SUPERVISOR
PRECEPTOR
EDUCATOR
ROLE MODEL

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- **Andrew Cates**, Director of Governmental Affairs for the Texas Nurses Association
- **Kathy Thomas**, MN, RN, FAAN, Director for the Texas Board of Nursing
- **Pam Lauer,** Program Director for the Texas Center for Workforce Studies
- **Peter McMenamin**, PhD, Senior Policy Fellow for the American Nurses Association
- **Matt Thornhill**, Generations Matter
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Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Navigating the World of Social Media

Provided by the American Nurses Association

The number of individuals using social networking sites such as Facebook, Twitter, LinkedIn, and YouTube is growing at an astounding rate. Facebook reports that over 10% of the world's population has a Facebook presence while Twitter manages more than 140 million Tweets daily.

Nurses are making connections using social media. Recently, the College of Nurses of Ontario reported that 60% of Ontario's nurses engage in social networking (Anderson & Puckrin, 2011).

Social networks are defined as "web-based services that allow individuals to 1) construct a public or semi-public profile within a bounded system; 2) articulate a list of other users with whom they share a connection; and 3) view and traverse their lists of connections and those made by others within the system" (Boyd and Ellison, 2007).

These online networks offer opportunities for rapid knowledge exchange and dissemination among many people, although this exchange does not come without risk. Nurses and nursing students have an obligation to understand the nature, benefits, and consequences of participating in social networking of all types. Online content and behavior has the potential to either enhance or undermine not only the individual nurse's career, but also the nursing profession.

Benefits

- Networking and nurturing relationships
- Exchange of knowledge and forum for collegial interchange
- Dissemination and discussion of nursing and health related education, research, best practices
- Educating the public on nursing and health related matters

Risks

- Information can take on a life of its own where inaccuracies become "fact"
- Patient privacy can be breached
- The public's trust of nurses can be compromised
- Individual nursing careers can be undermined

ANA's Principles for Social Networking

1. Nurses must not transmit or place online individually identifiable patient information.
2. Nurses must observe ethically prescribed professional patient — nurse boundaries.
3. Nurses should understand that patients, colleagues, institutions, and employers may view postings.
4. Nurses should take advantage of privacy settings and seek to separate personal and professional information online.
5. Nurses should bring content that could harm a patient's privacy, rights, or welfare to the attention of appropriate authorities.
6. Nurses should participate in developing institutional policies governing online conduct.

References:

Anderson, J., & Puckrin, K. (2011). Social network use: A test of self-regulation. *Journal of Nursing Regulation*, 2(1), 36-41.

Boyd, S., & Ellison, N.B. (2007). Social network sites: Definition, history, and scholarship. *Journal of Computer Mediated Communication*, 13(1), 210-230.

Membership in TNA is About You and Your Profession

The Texas Nurses Association has always been about advancing the nursing profession and its practitioners.

Since 1907, when TNA's first members set out to define and regulate nursing through legislative advocacy, nurses and patients in Texas have benefited. Legislatively achieved gains in Texas have been significant for nursing practice. Now, more than 100 years later, TNA members continue the work through collaboration and vision.

Speak out for your practice

With professional membership in TNA, you can be a powerful voice that speaks boldly for nursing; boldly for the practice environment. Membership enables you to become a full participant in defining what your profession is and what it should be.

Both during the Texas Legislature and between sessions, TNA works tirelessly for nurses and the nursing profession as your voice at the Texas Legislature.

Join BOTH for just $174/yr.

Joint membership in TNA and ANA is now highly accessible and affordable at only **$15/ month or $174/year**. Together with TNA, ANA represents the largest and most inclusive group of nurses in the country.

You'll have full access to resources that will help you:

- Enhance your skills through ANA online continuing education
- Meet new peers and colleagues
- Learn the latest association and industry news through Texas Nursing publication
- Continue your higher education through ANA's education alliance discounts
- Advance your career with TNA's Career Center
- Develop your leadership skills
- Utilize TNA-member discounts and deals

Best of all, your voice will be heard when TNA speaks out on crucial nursing issues.

Winkler County Nurse Whistleblower Case Shows Why Prosecuting Corruption Cases of State Officials in their Home Counties is a Bad Idea

Toni Inglis, MSN, RN, CNS, FAAN

Toni Inglis

The following is a reprint of a June 17 commentary that appeared on the editorial page of the Austin American-Statesman. On June 18, Gov. Greg Abbott signed the bill into law, which goes into effect on Sept. 1.

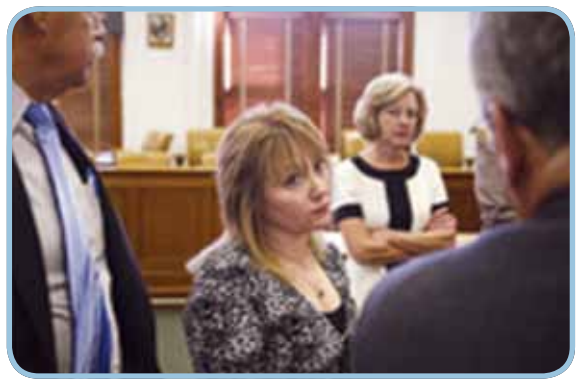
As Republicans pound their chests trumpeting the success of the 84th legislative session, many of us are left wondering which was the lousiest bill passed. Open carry? Guns on campus? "Repatriating" Texas gold bullion from Fort Knox to a depository in Texas — huh? Let's not forget failing to pass a ban on texting while driving.

My pick for worst bill passed was HB 1690, the one removing corruption prosecution of public officials and state employees from the Travis County Public Integrity Unit to the home counties of those being investigated, with the Texas Rangers doing the official's initial investigation. All of us know that good-ol'-boy clubs are as emblematic of Texas as cowboys and oil wells; doesn't the Legislature?

You have to look no further than the Winkler County whistleblower imbroglio to see how local prosecutions can go bad and why this law stinks. But you have to look pretty far west; it's located in the dusty Permian Basin practically on the border with New Mexico.

Here's how the story goes: Kermit (population 5,000) desperately needed a doctor. An affable Rolando Arafiles rode into town. The town's prominent good ol' boys all liked the smiling doctor. So, despite having a stipulation on his medical license for corruption in Corpus Christi, the hospital hired him in 2007.

By the following year, a doctor, a nurse practitioner and two quality assurance nurses



employed by Winkler County Memorial Hospital, separately reported Arafiles to the Texas Medical Board for substandard care. After the medical board sent Arafiles the reports with names redacted, he complained of harassment to his golfing buddy, the sheriff.

Through nefarious means, the sheriff found the nurses' report to the board on one of the nurse's computers. The hospital administrator immediately fired the nurses, and the county attorney charged the nurses with misuse of official information, a third-degree felony

punishable by up to a $10,000 fine and 10 years in prison.

No nurse ever had been criminally prosecuted for reporting a doctor, and national headlines were made. One of the nurses chose to retire early, and charges against her were dropped. But the case against the other nurse, Anne Mitchell, went to trial. After four days of a trial attended by nurses from across the state and a reporter and photographer from the New York Times, Mitchell was acquitted in less than an hour.

Smelling rot, in an anomalous 180-degree judicial turnaround the attorney general's office investigated and charged all members of the good-ol'-boys club — the doctor, sheriff, hospital administrator and county attorney — with two counts each of two felonies: retaliation and misuse of official information.

All were found guilty, resigned their positions, were fined and served time behind bars. The doctor, sheriff and county attorney all lost their professional licenses. Justice was served, but not for the two nurses whose brilliant careers were ended for exercising their ethical duty to protect the public. And not for Kermit, the previously peaceful town that was, and remains, torn apart.

David Glickler, a Hays County judge and former assistant attorney general who so brilliantly prosecuted the case against the local officials, told me he believes the Winkler County case was a prosecutorial aberration. But Sen. Kirk Watson (D-Austin) believes the bill in effect leaves "legislators proclaiming themselves and statewide elected officials as a privileged class with benefits their constituents don't have." Amen.

It took a statewide prosecution to right the wrongs of a local prosecution. Gov. Greg Abbott has refused comment on the bill, but we'll know within a week if he allows it to become law without his signature. As former attorney general, he above anyone should know that this bill doesn't pass the sniff test and that corruption cases of state officials should be prosecuted by a statewide entity, like say, the attorney general's office. The Texas Rangers already investigate most of their cases anyway.

It's only because the nurses' case received national media attention that the local villains came to justice. It's hard to shine the light of day on all 254 Texas counties in this huge state with vast rural and frontier areas — and lots of small good-ol'-boy clubs made up of the counties' prominent citizens who have personal and business relationships with each other.

Toni Inglis, a longtime TNA member, is a retired neonatal intensive care nurse and editor living in Austin. She writes a monthly opinion column for the *Austin American-Statesman*.

SB66 Epinephrine Auto-Injectors in Texas Schools

Senate Bill 66 sponsored by Sen. Chuy Hinojosa (D-Nueces) and Rep. Myra Crownover (R-Denton) was signed into law May 28, 2015, by Gov. Abbott allowing Texas public schools and publicly funded charter schools to stock epinephrine auto-injectors for school personnel to use on any student who suffers an anaphylactic reaction at school or at an after school event. The bill also includes appropriate liability protections for physicians, those involved in training and health care workers or other providers involved in the administration of the auto-injectors.

"The Texas School Nurses Organization (TSNO) supports laws and regulations which allow the maintenance of stock non-patient specific epinephrine and physician-standing orders for school nurses and trained school staff to administer epinephrine in life-threatening situations in the school setting," said Francis Luna, President of the Texas School Nurses Organization. "The school nurse is the key school professional to lead the school staff in the awareness, prevention and treatment of life-threatening allergic reactions keeping students safe at school and ready to learn is one of our top priorities."

An estimated one in 13 or 8% of US children has a food allergy – a common cause of anaphylaxis and a major public health concern in the US, according to the Food Allergy Research and Education Group. The number of school children in Texas with life threatening food allergies is estimated to be 160,000. Other common causes of anaphylaxis include insect allergy, latex and antibiotic allergies. SB66 is named The Cameron Espinosa Bill in memory of the Corpus Christi middle school athlete who wore jersey number 66. In September 2013, he was stung by fire ants on a school football field and immediately developed a severe systemic reaction. No epinephrine was available until EMS arrived and during the delay Cameron went into shock and respiratory failure. Had this child received immediate treatment with epinephrine at the football field, his likelihood of survival would have dramatically improved.

For 25% of children, the first episode of food related anaphylaxis occurs at school. Fire ant and other stinging insects can also cause severe allergic reactions resulting in death in the school setting.

Epinephrine is the only first line treatment indicated for an anaphylactic reaction according to the National Institute of Allergic and Infectious Disease guidelines. Timely administration of an epinephrine auto-injector is a child's first and primary line of defense in the event of an anaphylactic reaction. Only 25-28% of allergic children have access to an epinephrine auto-injector at school and 30% of school nurses have reported using one student's prescribed medication to rescue another student in distress. Failure to administer epinephrine promptly has been reported as the most important factor contributing to death from anaphylaxis. Epinephrine is a naturally occurring hormone. When given as a medication, epinephrine is available only in injection form. There are no negative side effects to giving epinephrine to a patient who is later determined to have not needed it.

The Texas Allergy, Asthma & Immunology Society assisted in writing and lobbying on behalf of SB66 and will continue to support and train school nurses and other personnel so that the 160,000 allergic students can be treated appropriately. Two pharmaceutical companies have the auto-injectors available free or at reduced cost for Texas public schools to be appropriately stocked. The TAAIS also has free training available for school nurses and other personnel who may be involved in their use.

Further information is available by contacting *cmawer@taais.org* or *LBethea@allergyasthmadoc.net*.

Health Information Technology (HIT) Resolution

In 2010, the Texas Nurses Association and the Texas Organization of Nurse Executives joined together to investigate the use of electronic health records, identify where they are most and least successful, and make recommendations for improvement.

The resulting Health Information Technology (HIT) Committee has been extremely active. Most recently, the committee has conducted a survey of Texas nurses concerning their use of electronic health records. The committee is busy processing and evaluating the responses. The full results will be released later this year.

Meanwhile, TNA's House of Delegates and TONE's board each passed the following resolution in support of the work of the HIT Committee.

Whereas, the health care industry has made significant advances in the use of health information technology since 2010;

Whereas, the health care industry and health care professionals are committed to working toward the optimization and widespread adoption of electronic health records fully demonstrating meaningful use by 2016;

Whereas, the health care industry is working toward interoperability of health information technology infrastructure within and among health care organizations and health care professionals by 2024;

Whereas, the widespread adoption of electronic health records, patient portals, and social media has led to the engagement of patients and communities as partners in care;

Whereas, electronic health records provide a means to electronically capture core measures promoted by the National Quality Foundation (NQF) and the Centers for Medicare and Medicaid (CMS) reflecting nursing's contributions to patient outcomes;

Whereas, nursing must continue to transform itself as a profession in order to make full use of the capabilities that electronic records and other health information technologies will provide;

Whereas, nurses must seamlessly integrate information into practice;

Whereas, nurses are key members of the inter-professional patient care teams;

Whereas, nurses in education and practice settings need access to evidence-based knowledge;

Whereas, the Technology Informatics Guiding Education Reform (TIGER) is an initiative involving nurse stakeholders that aims to create a vision for the future of nursing that bridges the quality chasm with information technology, by establishing competencies that enable nurses to use informatics in practice and education to provide safer, high-quality patient care; therefore be it

Resolved, that the Texas Nursing Association and the Texas Organization of Nurse Executives will:

- Promote the competent use of health information technology;
- Actively participate in the planning development and implementation of IT for the state of Texas;
- Work with other organizations to measure and monitor progress towards implementation of meaningful use.

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