Nurse Staffing: Finding Solutions for Nurses and Patients
A colleague of mine who was working on nurse staffing issues at our hospital once told me nurses don’t want to work in an over-staffed environment. She pointed out that as soon as it seems we have too many nurses working in a unit, nurses volunteer to go home. Her words have resonated with me for several years. She was exactly right – both then and now.

The nurses I have known take every opportunity to go home early when they are not needed, and charge nurses keep a constant eye on the fiscal impact of their staff utilization.

Why, then, do nurses feel they are blamed when their units are staffed at or above the unit’s budget allocation?

Often patient acuity is higher than expected so nurses request additional nurses be assigned to safely care for those patients. Instead of being hailed for their astute nursing judgment, RNs often have their decisions scrutinized and they must defend every decision that has a fiduciary component.

Fear of such confrontations contributes to nurses erring in their judgment that often results in utilizing a minimum number of staff rather than re-aligning the work flow so that nurses can attend to often neglected tasks, including self care.

It has become a nationally recognized failure in our profession when nurses report that they rarely or never take their rest and meal breaks without interruption of ongoing patient care responsibilities. How can nurses missing their breaks be healthy for patients? The answer is simple – it is not!

Lack of adequately trained staff who are capable of providing much needed rest periods for nurses is, in fact, a serious patient safety issue. Yet it is rarely given serious consideration by health care administrations.

Other patient safety indicators such as patient falls or infections are closely monitored and remedied, but ensuring that the staff caring for these patients has sufficient rest after several grueling hours of work is simply not acknowledged as a concern, despite strong evidence of the negative effects of fatigue on decision making and physical performance skills.

Caring for the health and well-being of nurses is essential. With an aging nursing workforce, in a time of economic uncertainty and the promise of an increasing patient population, we must find ways to enable nurses to continue to work successfully in all settings across the health care continuum.

In order to do so, we must begin to explore all possibilities in order to ensure that nurses will stay engaged in their practice for as long as possible.

– What if staffing decisions ensure that breaks were taken by staff?
– What if budget calculations were adjusted to only align with comparator hospitals that could accurately document that 90 percent of nurses took their breaks?
– What if administrator bonuses were tied to nursing satisfaction scores as they relate to nurses’ perceptions of their fatigue and stress?
– What if the Joint Commission (JCAHO) assessed nurses’ rest periods as part of their evaluation process, and placed facilities on improvement plans for ensuring nurses had adequate rest to keep patients safe? Would we see a shift in our health care culture then?

I urge all of my nurse colleagues to think outside the box as we seek to improve our professional practice in every area involving staffing issues that threaten our personal health, our patients’ well-being, and the health of our nursing profession.
The title, noted above, is a quote attributed to William Bruce Cameron from his writing in the 1960s, and given the current focus on “metrics” in the health care industry, it seems very relevant today. Nurses experience more and more emphasis on measurements of activities and outcomes (or lack of events) as our delivery system tries to find its footing and grapples with issues of quality. But what is behind these metrics? Let’s examine a few.

A prominent, publicly reported metric is a hospital score on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS). While not posing an analysis of the psychometric validity of the tool, nurses and other providers are asking if it measures what we believe is important. Questions one and five ask patients if nurses and physicians treated them with courtesy and respect. This is a good thing to measure and is one of the tenets of our Code of Ethics. On the other hand, question 20 asks if the patient received information in writing about symptoms or health problems to be aware of after they left the hospital. What would a “yes” mean? It could mean that the patient was given six to eight pages of written material by a nurse who had the time to review what was written or alternatively by a nurse who did not. And given the complexity of post-hospital care plans for many patients, written materials alone can be less than useful.

One of the most common measures of glycemic control is the Hgb A1c. Provider performance is measured by it. Patient adherence to a self-management regime is evaluated using it. But how does the patient with a value of the goal of six or less feel? If the normal value is achieved by periods of hypoglycemia, not very well. And with our primary care providers expected to see patients in 15 minute visits, how much information other than numbers can be obtained?

And my favorite metric – In Oregon, adoption of the electronic health record is one of the measures that Coordinated Care Organizations (CCOs) must report to the Center for Medicare Medicaid Services (CMS). What would 100 percent adoption mean? Certainly information can be extracted from these records about what services were provided to patients, but how valuable is the information? Cut and paste, click boxes and the use of “dot phrases” make patients look the same and yield little information for providers about that specific patient’s needs and care.

When I look at the “departure condition” information that I just recorded in EPIC, nothing is told about that patient unless I attach a note, and the amount of space for that note is very limited. Maybe that doesn’t matter in the world of measurement but it certainly does for me as a nurse and for our goal of achieving patient and family centered care.

For those in our profession who like to measure, here are a few metrics that might be worth exploring:

– the number of shifts that units in a hospital that were staffed appropriately
– the number or percentage of any facility or provider’s patients who acknowledge they were given detailed information about alternatives for their care and had a full discussion about those alternatives
– the scoring used by health system boards to determine the size of their administrator’s bonuses.
– the number of medications prescribed that are necessary and beneficial for a patient

As a nurse, it is gratifying to me that our industry has placed so much emphasis on evaluating the quality of the care we provide even if our measurement is still in its infancy. But it is important that we direct our metrics toward what will improve both our patient’s experience and their health status as well as spending their money wisely and on needed and beneficial services.
Perhaps now more than at any time in my nursing career, nurses seem exhausted, overworked and truly worried about the future of their own nursing practice.

I recently spoke to a nurse who had been required to work 23 hours straight in a busy operating room. Another RN said that she had worked well over 70 hours in a work week and was feeling “burned out.” Both dedicated nurses shared their concerns for patient outcomes – that their exhaustion would inadvertently adversely affect their patients.

These nurses’ concerns are warranted. Trinkoff and colleagues’ (2011) study of 2,600 nurses in various settings found that patients experienced increased pneumonia deaths when nurses worked long hours and had a lack of time away from work.

Further, the study suggested a relationship between nurses working long hours and poor outcomes for patients with abdominal aortic aneurysms, congestive heart failure and myocardial infarction.

Other studies suggest a link between long work hours and the affinity for more medication errors, catheter associated urinary tract infections (CAUTI), falls and nosocomial infections (Stone et al., 2007; Rogers et al., 2004; Olds and Clarke, 2010).

Not only are long work hours for nurses associated with poor patient outcomes, some research suggests these nurses experience more fatigue and poor sleep quality, resulting in poor reaction times and decision making abilities (Geiger-Brown et al., 2011; Trinkoff et al., 2011). Trinkoff and colleagues (2006) noted that nurses with neck, shoulder and back disorders were more likely to work 13 plus hours, work while sick and to have worked mandatory overtime.

Some researchers have made the correlation between long work hours and physiologic symptoms similar to alcohol intoxication. The research suggests that when people work over 17 hours their cognitive and psychomotor performance deteriorates to equal that of someone with a blood alcohol level of .05% (1 drink) and if they worked 24 hours straight, the feelings were similar to a blood alcohol level of 0.10% (2 plus drinks), which would be considered legally drunk in many states (Dawson & Reid, 1997).

Fortunately, there is a nurse staffing law in Oregon that protects nursing staff from administrators who require mandatory overtime. Except for a few specific situations, a hospital cannot require an RN, LPN or CNA to work:

– beyond the agreed-upon shift,
– more than 48 hours in any hospital-defined work week,
– more than 12 consecutive hours in a 24-hour period.

As an exception, a hospital may require an additional one hour of work beyond the end of the current shift if:

– a staff vacancy becomes known at the end of a shift or
– there is risk of harm to an assigned patient if the nurse leaves the assignment or transfers care to another.

The nurse staffing law also requires that organizations have a hospital-wide nurse staffing committee consisting of equal number of staff nurses and management. It is the role of the staffing committee to design a staffing plan that ensures skill mix and competency of the staff meet the nursing care needs of the patient.

The plan must also be consistent with nationally recognized evidence-based standards and guidelines established by nursing specialty organizations (when available).

Hospitals must evaluate and monitor the staffing plan for effectiveness and revise the plan as necessary to improve patient care at a minimum of once per year.
U.S. Senator Jeff Merkley on Hospital Nurse Staffing

As the husband of a nurse, I know firsthand how hard nurses work and the many challenges they face delivering the best care to their patients. My wife Mary has shared with me her experiences on the front lines of patient care. Nurses bring a strong sense of dedication and compassion to their work and it is important that they have safe work environments so they can focus on ensuring quality patient outcomes.

As Oregon’s United States Senator, I have been a strong advocate for nurses. I co-founded the Senate Nursing Caucus with Senator Olympia Snowe (R-ME) to begin a dialogue in the Senate on ways we can strengthen the nursing profession and advance its goals, including ensuring that we have enough nurse educators to train tomorrow’s nurses.

I have heard from nurses across Oregon about the importance of appropriate staffing levels at hospitals. Having the right number of nurses on shift enhances patient care, reduces medical errors and bolsters nurse retention. According to a study published in the New England Journal of Medicine, higher levels of nursing care correspond to better patient care and outcomes at hospitals. We can and must do more to ensure there are safe staffing levels at our nation’s hospitals.

In May, I introduced the Registered Nurse Safe Staffing Act (S. 2353) in the Senate. The bill would require Medicare-participating hospitals to create safe staffing plans and ensure that an appropriate number of registered nurses are available to provide direct patient care during any shift, based on key factors such as the number of patients and the intensity of care needed.

Adequate staffing levels help to ensure the safety of nurses and their patients and to reduce nurses’ stress and burnout. This is essential now more than ever, as more nurses retire and the demand for nurses increases as our population ages and more Americans gain access to health insurance coverage.

Seven states, including Oregon, have passed similar legislation and I’m proud to say that the bill has been endorsed by the American Nurses Association. Please know I will continue to work with my colleagues in the Senate to pass this important legislation.

ONA is proud to endorse Senator Jeff Merkley for re-election in 2014. Throughout his career in public service, Senator Merkley has been an effective advocate for nurses and a thoughtful proponent of meaningful health care reform.

He co-founded the Senate Nursing Caucus to provide a forum for senators to address issues that affect the nursing community, and in 2014, he introduced the Registered Nurse Safe Staffing Act (S. 2353).

The RN Safe Staffing Act would incorporate and improve upon Oregon’s nurse staffing committee model, while also expanding transparency and enforcement measures and increasing nurses’ input in determining safe staffing levels.

He credits his wife, Mary Sorteberg, RN, for influencing many of his views on health care.

A native Oregonian, Jeff and his wife Mary live in outer S.E. Portland with their two children.
Staffing Request and Documentation Forms (SRDFs) are filled out by staff nurses or charge nurses in an acute care facility to document the occurrence of an inappropriate staffing event on a specific shift and unit. SRDF content is shared with both hospital management and the Oregon Nurses Association (ONA).

In our 2014 report, ONA provides analysis of 1,780 SRDFs submitted from a two-year period from May 1, 2012, to April 30, 2014. Key observations from the analysis are highlighted below.

• There was a 5.3 percent year-over-year increase of total SRDFs submitted.

Summary of Factors Related to Why a SRDF was Submitted

• 84 percent of the SRDFs were submitted from an eight hour shift.

• 46 percent were submitted from a day shift and 35 percent were submitted from night shifts.

• Nearly 33 percent of the SRDFs were submitted from the ICU (12.5 percent), General Medical (11.0 percent), Emergency Room (9.2 percent) units.

Summary of the Identified Reasons for Requesting Additional Staff

• 89 percent noted that not having enough staff was a reason for submitting the SRDF.

• 59 percent indicated high patient acuity and 44 percent indicated that patient care intensity was too high as reasons for submitting the SRDF.

The results from our analyses support the adverse effect of inadequate staffing on delaying or omitting patient care tasks, compromised patient safety and missed self-care activities.

Summary of the Reported Consequences of the Insufficient Staffing Event on Care Task Delivery

• 82 percent of pain management, 90 percent of medication, and 91 percent of medical orders and treatments were reported as being delayed or omitted due to insufficient staffing on the unit.

• Not enough staff, patient intensity, and patient acuity were significantly related to the delay or omission of almost all of the measured care tasks.

Summary of the Reported Patient Safety Consequences of Insufficient Staffing

• 71 percent report that the staffing event compromised patient safety and 30 percent indicated that continuity of care was impacted.

• There was a 1.5 to two times greater likelihood that compromised patient safety was reported when not enough staff, patient acuity being too high, and inappropriate staff mix were identified as a reason for submitting the SRDF.

Reported Self-Care Consequences of an inadequate staffing event

• 78 percent reported missed rest breaks, 55 percent reported missed meal breaks, and 31 percent indicated they worked voluntary overtime.

• When patient intensity was indicated, there was at least a 1.7 times greater likelihood that nurses reported voluntary overtime, missing meal breaks and missing rest breaks.
Every nurse has dealt with the challenges of inadequate or unsafe staffing. Nurses may feel pressured to take on an additional patient, float to a unit where they are not familiar with the patient populations’ needs or handle too many patients whose acuity is too high.

The negative effects of inadequate staffing can range from stress and burnout for nurses to serious effects for patients, including compromised patient care, patient injury or in rare cases, patient mortality.

As patient advocates, it is nurses’ responsibility to speak up when a patient’s care is compromised. ONA members have done just that, documenting more than 1,000 instances of inadequate or unsafe nurse staffing in ONA facilities in 2013 through Staffing Request and Documentation Forms (SRDFs).

SRDFs provide an important avenue for reporting inadequate or unsafe staffing situations when managers and administrators are unwilling or unable to correct staffing problems.

This situation is becoming all too common. Between 2010 and 2013, SRDF submissions have increased by 114 percent, going from 534 to 1,143 per year.

This rise in reports of inadequate or unsafe staffing has resulted in two separate ONA House of Delegates Action Reports, calling on ONA to further study nurse staffing problems and push for improvements to Oregon’s Nurse Staffing Law during Oregon’s 2015 Legislative Session.

Thanks to the work of ONA’s Nurse Staffing Law Review Group, ONA nurses and partners have developed the recommendations for improvements to Oregon’s Nurse Staffing Law.

These recommendations build on the collaborative staffing committee structure created by previous legislation, while empowering staffing committees, enhancing transparency, improving enforcement, increasing accountability and adding necessary requirements and clarifications.

ONA plans to use these recommendations as a framework for nurse staffing legislation in 2015.

Summary of Recommendations for Changes to Oregon’s Nurse Staffing Law

Developed by ONA’s Nurse Staffing Law Review Group

Empower Direct-Care Nurses on Staffing Committees: Clarify that staffing committees have the final say in staffing plans. Modify membership of staffing committees and selection of direct care staff to create fair representation. Incorporate a role for nurse-to-patient ratios.

- Hospital Nurse Staffing Committees (HNSCs) decisions’ must be implemented by their facility.
- A vote must be taken to confirm any HNSC impasses
- HNSC must notify Health Care Regulation Quality Improvement (HCRQI) of an impasse.
- Impasses trigger an upwardly adjustable HCRQI-established ratio at the unit level.
- The ratio remains in place until HNSC approves a staffing plan.

Enhance Transparency: Increase Access to Staffing Information

- Investigation and audit reports, staffing plan annual reviews, violations and plans of correction must be readily available on HCRQI’s website.

ONA Nurses Seek Improvements to Oregon’s Nurse Staffing Law

Sarah Baessler, BA, BS, Director of Health Policy and Government Relations, ONA
• Staffing law and instructions on how to report a violation must be posted in every patient room.
• Current unit’s RN and aide to patient ratio must be publically posted in each unit.

**Mandatory Overtime:**

• Change language around “beyond agreed-upon shift” to read “Beyond the agreed-upon and predetermined shift, regardless of shift length, so long as no shift exceeds 12 hours in a 24 hour time period, including time called back to work.”

• Specify that a hospital may not require a nurse to work an assignment of overtime if, in the judgment of the nurse, the overtime would jeopardize patient or employee safety.

• Require 10 hours off after a nurse works 12 hours in a 24 hour period.

• Prohibition on scheduling non-emergent cases during times the unit is generally closed

**Increase Accountability:** Create a collaborative advisory board to ensure best practices

• Create a 13 member advisory board to HCRQI.

• Advisory Board will identify trends and problems with nurse staffing based on audits, complaints, investigations and annual staffing plan reviews submitted to HCRQI.

• Advisory Board will resemble collaborative staffing committee model and include representation from staff nurses and nurse managers, as well as member(s) of the public.

• Advisory Board will set ratio for units that do not have a national specialty standard.

• Advisory Board will report to the legislature annually.

**Additional Staffing Plan Requirements:** Create more comprehensive staffing plans

• Staffing plan must consider admissions, discharges, transfers, breaks and additional non-direct care required tasks.

• Staffing will be determined based on 24 hour census consideration.

• Plans cannot rely solely on external benchmarking measures.

• Replace “acuteness” with “acuity” in staffing plans.

• Include the concept of workload intensity for nursing staff.

Click here to view or download all of the Staffing Law Review Group’s Recommendations.

Sign up to support these efforts by pledging to improve Oregon’s Nurse Staffing law on ONA’s Web site www.OregonRN.org and join ONA at the State Capitol in Salem on February 10, 2015 to talk directly to legislators and staff about the importance of safe and appropriate staffing for both nurses and patients.
Two Important Questions Surround Patient Satisfaction Involving Value of Care Received

Carl Brown, PhD, RN, AOCN®, FAAN
Director of Professional Services ONA

I’ve recently been posed these two important questions surrounding patient satisfaction:
How will patient satisfaction affect future hospital reimbursement revenue? Where and how do nurses play into the reimbursement process?

The answers are important and not always easily understood.

With the creation of the Patient Protection and Affordable Care Act (PPACA) of 2010, the patient was actually placed in the forefront of health care. Now more than ever, patients’ opinions of the care they receive will actually be taken into consideration and will absolutely affect how hospitals are reimbursed via Medicare/Medicaid. No longer are hospitals paid for the volume of their services, but instead will focus on the value of the care.

The patient experience is measured by the Hospital Consumer Assessment and Healthcare Providers and Systems (HCAHPS) survey. To view or download more information click or go to the following link: [HCAHPS%20V9.0%20Appendix%20A%20-%20Mail%20Survey%20Materials%20(English)%20March%202014.pdf](http://hcahpsonline.org/files/HCAHPS%20V9.0%20Appendix%20A%20-%20Mail%20Survey%20Materials%20(English)%20March%202014.pdf). The HCAHPS focuses specifically on communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment and transition of care. The HCAHPS survey is a 32 question survey that asks the patient to evaluate certain services that occur during an inpatient stay.

Examples of questions included in the survey are:

- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen carefully to you?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- Would you recommend this hospital to your friends and family?

The HCAHPS provides data in the form of patients’ voices which tell the story of the quality of health care in individual hospitals and it allows that data to be compared across hospitals. Mediocre or poor patient satisfaction scores will be costly to health care organizations.

The reduction of hospital reimbursement revenue based on performance will be decreased by 1.25 percent in 2014, 1.75 percent in 2016, and 2 percent in 2017 for those hospitals with mediocre to poor HCAHPS scores.

Said differently, in 2014 the amount at stake in lost reimbursement for poor or average performing hospitals is estimated at $1 billion. To take it a step further, those hospitals that are high performers (high in patient satisfaction) could see their reimbursements revenues increase to 1.5 percent in 2014.

Hospitals will also be evaluated by the Centers for Medicare and Medicare Services (CMS) on other outcomes besides patient satisfaction, which include hospital readmissions and hospital acquired conditions (such as falls, infections, etc).

Nurses are integral to almost all of the 32 questions asked in the HCAHPS survey. Successful hospitals understand that nurses should be viewed as a way to improve patient outcomes but also to make revenue for the organization.

Hospitals that decrease nurses or make nurses care for more patients as an easy way to save money immediately will undoubtedly lose revenue in the long run.

In coming issues of Oregon Nurse, I will discuss evidence-based interventions that can help organizations improve their HCAHPS scores.

For more information on HCAHPS click/go to: [www.hcahpsonline.org/home.aspx](http://www.hcahpsonline.org/home.aspx).
Although November seems far off, it’s time to begin contemplating
your vote and what it might mean for the nursing profession in Oregon.

State legislative races are critical to ONA’s efforts to pass meaningful nurse staffing reforms during Oregon’s 2015 Legislative Session. Safe nurse staffing is just one of many legislative issues that impacts ONA members – and the patients you care for – in every area of the state.

The Oregon Nurses Political Action Committee (ON-PAC) and the nurses United Political Action Committee (ON-PAC) have been hard at work, meeting with candidates all over the state to determine who will be the best advocates for nurses, public health and organized labor, and which ballot measures will benefit our members and their patients. Click here to view a current list of ONA’s endorsements for the November 2014 General Election.

Who we elect matters. During the 2013 legislative session, bill after bill failed to pass because it lacked the support of one additional legislator. Many of ONA’s priorities, including ensuring manufacturers disclose the presence of toxics in children’s products, providing workers opportunities to earn sick time on the job and increasing Oregonians’ access to the ballot, did not pass because of the votes of only a few legislators.

Working to elect leaders who truly understand nursing issues will help set us up for success in 2015. We need more advocates like Representative Rob Nosse (D, Portland). Rob has worked with nurses at ONA for more than 9 years. He’s fought hard to protect staffing levels and has helped elevate the voices of the nurses he’s represented for nearly a decade. It is good to know we’ll have someone like Rob to support our nurse staffing reforms in Salem, but he can’t do it alone.

We need to continue our work to ensure every member of the legislature understands the staffing challenges Oregon’s nurses and patients are facing and make sure they are ready to take action.

We Need to Make Sure We Elect the Right Candidates for the Job November 4, 2014.

U.S. Senate
(endorsements made in collaboration with ANA)
• Senator Jeff Merkley (D-Portland)

Congressional Races
(endorsements made in collaboration with ANA)
• CD 1: Congresswoman Suzanne Bonamici (D-Beaverton)
• CD 2: Congressman Greg Walden (R-Hood River)
• CD 3: Congressman Earl Blumenauer (D-Portland)
• CD 5: Congressman Kurt Schrader (D-Canby)

State Races
• Governor: John Kitzhaber

State Senate
• SD 3: Senator Alan Bates (D-Medford)
• SD 4: Senator Floyd Prozanski (D-Eugene)
• SD 6: Senator Lee Beyer (D-Springfield)
• SD 7: Senator Chris Edwards (D-Eugene)
• SD 8: Representative Sara Gelser (D-Corvallis)
• SD 11: Senator Peter Courtney (D-Salem)
• SD 19: Senator Richard Devlin (D-Tualatin)
• SD 20: Jamie Damon (D-Eagle Creek)
• SD 23: Senator Michael Dembrow (D-NE Portland)
• SD 24: Senator Rod Monroe (D-Portland)

continued on page 11
ONA’s Candidate and Ballot Measure Endorsements

State House of Representatives

- HD 5: Representative Peter Buckley (D-Ashland)
- HD 8: Representative Paul Holley (D-Eugene)
- HD 9: Representative Caddy McKeown (D-Coos Bay/ Florence)
- HD 10: Representative David Gomberg (D-Lincoln City)
- HD 11: Representative Phil Barnhart (D-Springfield/Eugene)
- HD 12: Representative John Lively (D-Springfield)
- HD 13: Representative Nancy Nathanson (D-Eugene)
- HD 14: Representative Val Hoyle (D-W. Eugene)
- HD 16: Dan Rayfield (D-Corvallis)
- HD 20: Paul Evans (D-Monmouth)
- HD 21: Representative Brian Clem (D-Salem)
- HD 22: Representative Betty Komp (D-Woodburn)
- HD 27: Representative Tobias Read (D-Beaverton)
- HD 28: Representative Jeff Barker (D-Beaverton/ Aloha)
- HD 29: Susan McLain (D-Hillsboro)
- HD 30: Representative Joe Gallegos (D-Hillsboro)
- HD 31: Representative Brad Witt (D-Clatskanie County)
- HD 32: Representative Deborah Boone (D-Cannon Beach)
- HD 33: Representative Mitch Greenlick (D-NW Portland)
- HD 34: Ken Helm (D-Beaverton)
- HD 35: Representative Margaret Doherty (D-Tigard)
- HD 36: Representative Jennifer Williamson (D-SW Portland)
- HD 37: Representative Julie Parrish (R-Tualatin)
- HD 38: Representative Ann Lininger (D-Lake Oswego)
- HD 39: Representative Bill Kennemer (R-Oregon City)
- HD 40: Representative Brent Barton (D-Gladstone/Oregon City)
- HD 41: Kathleen Taylor (D-Milwaukie)
- HD 42: Rob Nosse (D-SE Portland)
- HD 43: Representative Lew Frederick (D-NE Portland)
- HD 44: Representative Tina Kotek (D-N Portland)
- HD 45: Representative Barbara Smith Warner (D-NE Portland)
- HD 47: Representative Jessica Vega Pederson (D-East Portland)
- HD 48: Representative Jeff Reardon (D-SE Portland, Happy Valley)
- HD 49: Representative Chris Gorsek (D-Gresham, Troutdale)
- HD 50: Carla Piluso (D-Gresham)
- HD 51: Representative Shemia Fagan (D-Clackamas, East Portland)
- HD 53: Representative Gene Whisnant (D-Sunriver)
- HD 57: Representative Greg Smith (R-Heppner)
- HD 59: Representative John Huffman (R-The Dalles)

Ballot Measures

OPOSE

Measure 90: Changes general election nomination process: provides for single primary ballot listing candidates; top two advance.

SUPPORT

Measure 88: Provides Oregon resident “driver card” without requiring proof of legal presence in the United States.

Measure 89: Amends Constitution: State/political subdivision shall not deny or abridge equality of rights on account of sex.

Measure 92: Requires food manufacturers, retailers to label “genetically engineered” foods as such; state, citizens may enforce.

In addition to supporting candidates with endorsements and financial support, we encourage nurses to volunteer with ONA on some of our top priority campaigns.

To learn how to get more involved in ONA’s political work, email baker@oregonrn.org.
AFT Convention Affirms ONA’s Decision to Affiliate with AFT

Paul Goldberg, RN, SBSN, BA
Assistant Executive Director for Labor Relations, ONA

ONA members and staff recently attended the national AFT convention. It was our first exposure to the range of leaders across both the health care and education divisions within our still new national affiliate. What was striking about the event and the issues that came forward was the symmetry between the concerns and struggles of teachers and nurses. The energy commitment to quality education for students, preservation of the authority of educators to drive education policy and manageable workloads rang familiar to nurses.

Education and health care have much in common and nothing could have been more clear than to hear it from the voice of articulate professionals who spoke from their hearts and minds.

While ONA and our fellow state nurses associations within the National Nurses Federation (NNF) were clearly the new kids on the block, I am proud that our presence was noted and that we were able to move action on issues that we know are important.

The report and recommendations from the Oregon Nurses Association on license jurisdiction for telehealth practice was approved by the AFT national executive council and now is the official position of a large powerful organization.

The report and recommendations on Cardio Pulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) training for school staff from the Oregon Student Nurses Association and ONA is under further review.

We supported Montana Nurses Association’s report and recommendations on supporting nurses in advanced practice which passed on the floor overwhelmingly.

As would be expected, the delegates supported appropriate hospital nurse staffing which is an issue of critical importance to nurses in all states.

There was much discussion about the impact of eliminating positions in schools that support the work of educators. The report titled “Medication Administration in the School” calls for AFT to lobby for and support federal, state and local initiatives that would institute and maintain school nursing positions.

There was also a theme of focusing our health care dollars on health services rather than exorbitant corporate infrastructures including CEO salaries.

The convention affirmed our decision to affiliate with AFT and its member professionals.

Our issues are so complimentary.

Our issues are the same.

Our issues matter to our students and to our patients.

They also matter to the future of our country.
Advocate Profile: Cheryl Brewer, RN

Cheryl Brewer has spent 14 years as a nurse on the cardiac unit at Sacred Heart Medical Center, Riverbend in Eugene. She sits on Sacred Heart’s staffing committee and is a member of ONA’s Cabinet on Health Policy.

Throughout her nursing career, she has supported individuals and groups that don’t always have strong advocates, including staff nurses and nursing students.

Here’s what Cheryl had to say about her work as a nurse advocate.

How did you decide to become a nurse advocate?

“I saw areas of patient care and safety that were not being addressed by the hospital at the same time that an opening came up on Sacred Heart’s staffing committee. The staffing committee seemed like a logical place for me to address some of the problems I saw. After I joined the committee, I had the ability to read through all the SRDFs (Staffing Request and Documentation Forms), nurses turn in. When I read them, I thought ‘Oh my god, this is crazy. I have to do something about this.’ So I took it upon myself to speak up even more about the safety concerns I saw in my unit and to address some of the hospital-wide concerns nurses have.”

What have you learned from your advocacy?

“I’m always surprised how thankful people are when you speak up about problems. I didn’t expect that. The nurses I talk to about what’s going on in our staffing committee or with negotiations are continuously thanking me and the other committee members for speaking up about the problems nurses face and for updating them on our progress.”

What advice would you offer to other nurses?

“Sometimes it only takes one person to speak up to get others to speak up too. It’s difficult to make changes if everyone stays silent. I know a lot of nurses feel they can’t speak up or don’t have the time to address big problems like staffing, but nurses need to take the time to advocate for ourselves and our fellow nurses as well as for our patients. We can’t take care of others if we don’t take care of ourselves.”

“There’s never been a more critical time to get involved. Big issues like staffing will continue to be challenges until we put in the effort and time needed to improve the situation for ourselves and our patients.”
Protect Your License, Protect Yourself

Should nurses and nursing students carry their own personal liability insurance policy? The answer is an unequivocal yes. Unfortunately, a contrary opinion is apparently being voiced by employers, faculty and nurses themselves. **You carry insurance to protect your home, your car and your health. Why not your career? Here are the reasons you should:**

First, a common assumption is that your employer will cover any incident. Technically, an employer is responsible for the acts of its staff. However, the employer’s interest is not necessarily consistent with protecting you individually. Should there be a lawsuit or threatened suit, your best protection is to have your own personal legal representation. Your own attorney can prepare you for a deposition, represent you in a deposition and, most importantly, represent you in any settlement and determination of fault.

Second, your employer’s policy does not represent you in an Oregon State Board of Nursing (OSBN) investigation. In fact, it could be your employer who makes the complaint to the OSBN about an alleged violation of law. The OSBN must investigate each complaint it receives and, even if the complaint is dismissed, there are costs to you.

The Oregon Nurses Association (ONA) recommends that all nurses obtain legal representation before responding to a letter from the OSBN related to a complaint. Most of the time, you are much more likely to receive a complaint from the OSBN than to be named in a lawsuit.

Third, you are always a nurse. You may render first aid or advise a family member or friend about a health problem. Should any incident arise about these acts, the only protection you have is your own personal insurance.

ONA urges you to obtain coverage from the Nurses Service Organization (NSO). For about $100 you can protect yourself. For example, should you be the subject of an OSBN investigation, you have up to $25,000 in coverage for attorney fees, travel etc. For more information please go to http://www.nso.com.

If you would like to discuss professional practice issues you may also call Carl Brown or Connie Miyao at the ONA office 503-293-0011.

Fall is Just Around the Corner – Practice Harvest and Hayride Season Safety

Hayrides are increasingly popular as social and fundraising activities. When fall harvest season is in full swing, hayrides abound. According to the National Safety Council hayride accidents have increased over the past several years. Organizers are encouraged to make sure their events are well organized and carefully monitored to prevent turning something fun into a tragedy.

A properly hitched wagon is critical. Not only should the wagon be securely hitched to the pulling vehicle, but safety chains should also be attached to ensure that the wagon does not disconnect while in motion. The pulling vehicle should move at a slow and steady speed. Do NOT hitch more than one wagon to a pulling vehicle at a time; extra wagons can create a “snaking” motion that may cause them or the towing vehicle to sideswipe other vehicles and even overturn.

The route the hayride takes is also important. If highways must be used, have escort vehicles with emergency flashers travel in front and in back of the wagon train.

Adult supervision is a must. Supervisors must make sure passengers are seated at all times and that horseplay – which could distract the driver – is not allowed.

This safety tip is provided by California Casualty Auto & Home Insurance, your ONA member benefit program.

For information about this benefit, visit www.calcas.com/ONA or call 1-866-680-5142
Research and Science (ORCAS) to adapt the classroom version of Fit to Perform to a computer-based format. The study was a National Institute on Drug Abuse (NIDA) funded project which enabled the use of an experimental design with a control group to evaluate the effectiveness of the computer-based adaptation of the training. Similar to the classroom version of the training, significant improvements in knowledge, intentions to use the information, self-efficacy and substance abuse stigma were observed in the experimental group. Statistically, there were significant mean differences on outcomes between the experimental and control groups. The positive effects of knowledge, intentions to use the information, and self-efficacy remained four weeks after the training. These results suggest that, like the classroom training, the online version of Fit to Perform offers an effective training resource for supervisors managing nurses enrolled in alternative programs.

Supervisors are the key personnel in upholding nurse performance standards and ensuring the safety of patients, health care professional colleagues, and individual staff nurses. Therefore, training nurse supervisors as worksite monitors of nurses in an ADP important.

Requiring specialized education should be considered by all nurse licensing boards for the sake of public safety, to uphold the ethical values of the nursing profession, and to support the individual nurse returning to work in recovery from SUD. Given the promising evaluation results from both the classroom and computer-based versions of the supervisor training, nurse supervisors can now access to at least two evidence-based training resources for nurses in ADP.

If you would like more information about the supervisor training or work at WorkHealthy Oregon, please contact Director, David Cadiz, cadiz@oregonrn.org.
2015 ONA Statewide Elections

January 16, 2015 is the deadline to self-announce candidacy for the statewide ONA elections. If you are interested in candidacy for any of the above positions, please complete the Talent Bank & Consent to Serve Forms, located on ONA’s Website under About ONA>Forms, and mail them to ONA 18765 SW Boones Ferry Road, Suite 200, Tualatin, OR 97062 or submit an online form on our website www.OregonRN.org. For more information, please contact Kathy Gannett at 503-293-0011 or 800-634-3552 ext. 309. Thank you.

2015 Open Positions

Vital Stats 8/08/14

Samaritan Pacific Communities Hospital, Newport
3-year agreement, 2% July 1, 2014
2% July 1, 2015, 1% July 1, 2016

Samaritan Albany General Hospital, Albany
3-year agreement, 2% July 1, 2014
2% July 1, 2015, 1% July 1, 2016

Marion County, Salem
2-year agreement, 3% July 1, 2014
1.5% July 1, 2015

Washington County, Hillsboro
3-year agreement, COLA July 1, 2014, COLA July 1, 2015, COLA July 1, 2016

Rogue Regional Medical Center, Medford
3-year agreement, 4% July 1, 2014, 3% July 1, 2015, 3% July 1, 2016

Sacred Heart Medical Center, Eugene
2-year agreement, 2% July 1, 2014, 2% July 1, 2015

Sacred Heart Home Care Services, Eugene
2-year agreement, 2% July 1, 2014, 2% July 1, 2011

On Call (Under Consideration)

Coos County, Coquille
Expiration 6/30/14

St. Alphonsus-Ontario, Ontario
Expiration 9/30/14

On Call (Upcoming)

Good Shepherd Hospital, Hermiston
Expiration 10/31/14

McKenzie Willamette Medical Center, Eugene
Expiration 12/31/14

Providence Home Health & Hospice, Portland
Expiration 12/30/14

Providence Portland Medical Center, Portland
Expiration 12/31/14

Providence Seaside Hospital, Seaside
Expiration 11/30/14

Providence Willamette Falls Medical Center, Portland
Expiration 12/31/14

Sky Lakes Medical Center, Klamath Falls
Expiration 12/31/14

St. Anthony Hospital, Pendleton
Expiration 12/31/14

2014 ONA Calendar

September 1
Labor Day Picnic by Northwest Oregon Labor Council, AFL-CIO

September 5
ONA Annual Bargaining Unit Leadership Conference – Cottage Grove

September 18
ONA Multnomah County Nurses Leadership Team Dinner

October 2
ONA Finance Committee Meeting – Tualatin

October 3
Board of Directors, ONA Headquarters – Tualatin

November 4-5
ONA Staffing conference – New Orleans

Executive Team: Executive Director Susan King, RN, MS, FAAN, king@oregonrn.org; Assistant Executive Director of Labor Relations Paul Goldberg, RN, BSN, BA, goldberg@oregonrn.org; Executive Director of Health Policy and Government Relations Sarah Baessler, BS, goldberg@oregonrn.org; Executive Director of Professional Services, Carl Brown PhD, RN, AOCN®, FAAN, brown@oregonrn.org; Director of Financial Officer, Robyn Belozer, belozer@oregonrn.org; Director of Professional Services, Carl Brown PhD, RN, AOCN®, FAAN, brown@oregonrn.org; Legal Counsel Alan Yoder, J.D., yoder@oregonrn.org; Associate Director of Operations Kathy Gannett, BA, gannett@oregonrn.org; Administrative Assistant, Linda Sidney, BSW, CMP, sidney@oregonrn.org.

The Oregon Nurse is the official publication of the Oregon Nurses Association, 18765 SW Boones Ferry Road, Suite 200, Tualatin, OR 97062, (503) 293-0011, email: ONA@oregonrn.org. For questions or comments, please contact ONA at ONA@oregonrn.org or (503) 293-0011.

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The Annual ONA Bargaining Unit Leadership Conference will take place Friday, September 5, 2014, 9:00 a.m. – 5:00 p.m. at the beautiful Village Green Resort in Cottage Grove.

This is a great opportunity for bargaining unit leaders to get together and discuss issues, challenges and successes the nurses in their bargaining units have experienced throughout the year. The event is open to bargaining unit chairs, co-chairs, and BU designees. ONA Student Affiliate Members and other leaders may attend with prior approval. Visit www.OregonRN.org for more information.

Join the Nurse Practitioners of Oregon (NPO) for the 37th Annual NPO Education Conference which will be held October 16-18, 2014 at the Sentinel Hotel (formerly The Governor Hotel) in Portland, Oregon.

Registration is now open for this great education conference designed to support the professional practice and learning needs of nurse practitioners, clinical nurse specialists, advanced practice nurses, physician assistants, and other interested health care providers by providing a variety of evidence-based educational topics.

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association (OBN-001-91) is an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.

Up to 23.5 nursing contact education hours will be available, pending approval.

Visit www.NPOregon.org for Details and Registration.