



# The Nursing Voice

ANA/C IS AN AFFILIATE CHAPTER OF THE AMERICAN NURSES' ASSOCIATION

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## Special Points of Interest:

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- NCSBN Embarks on an Innovative Multi-Site Transition —Page 9
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## President's Perspective

*Elissa Brown, President, ANA/C California*

Hi, all, and *Happy Spring!*

As you may already suspect, there are many exciting changes in health care and nursing. It is important to stay current with what is happening, since the changes affect nursing practice and care for the public. The best sources of information are your professional general nursing organizations, i.e., ANA/C California, and your specialty organization(s). Do plan in the next year, to join and/or maintain your membership and participate in something, in some way. Those who are involved carry the weight for all of us. If you are only able to pay your dues, that, too, is involvement, and helps your professional nurse colleagues to do the necessary legislative, practice, and education work to promote positive progress for Nursing and healthcare.



*Elissa Brown*

My hope for nurses is that while you are involved in making a difference—at work, in the community in the political and legislative arenas, that you truly love your profession. It makes it so much easier to do the caring work needed. A favorite quote, most relevant for nurses is:

*“What you do, what you say, what you are, may help others in ways you never know. Your influence, like your shadow, extends where you may never be.”*

*Anonymous*

I believe that Nurses should see themselves as those who keep the “caring” in healthcare—24 hours a day.

What is happening in healthcare? Most of you have received much information about the Robert Wood Johnson Initiative on the Future of Nursing, at the IOM. A number of our ANA/C officers and members attended the forums around the country and state; some of whom presented testimony that was incorporated into the report.

Our American Nurse Association President, Karen Daley, wrote an excellent article about this in the latest American Nurse Today journal. For your information, following is a summary of some of the key points (thank you to President Daley):

The Committee on the Robert Wood Johnson Foundation (RWJF) Initiative on the Future of Nursing (INF), at the IOM, reviewed and deliberated upon how the nursing workforce can best be utilized to meet the demands in health care and public health system reform. The report is titled: *–The Future of Nursing: Leading Change, Advancing Health, released by the Institute of Medicine (IOM) in October 2010.*

The INF committee developed four key messages/recommendations:

1. Nurses should practice to the full extent of their education and training,
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression,

3. Nurses should be full partners with physicians and other health professionals in redesigning health care in the United States.
4. Effective workforce planning and policy-making require better data collection and an improved information infrastructure.

President Daley's article continued with the issues-based on the above recommendations, which will be addressed in redesigning the healthcare system:

- quality care accessible to diverse populations
- wellness and disease prevention
- reliably improved health outcomes
- compassionate care across the lifespan
- diverse needs of the changing patient population

What can nurses in California do? There are and will be new chances to get involved. Statewide and local RACs, regional action coalitions, are already working together to transform and clarify the role of the nurse in health care and to increase access to high quality health care. Nurses are leading the way and ANA/C California has strong representative leadership in the RACs.

Other issues: ongoing concerns with Health Care Reform; as positions in government and coalitions open for RNs—we shall keep you updated. Please do check the American Nurses Association/California website and the American Nurses Association website: [www.nursingworld.org](http://www.nursingworld.org) for the latest information about, health care issues, healthcare reform and professional nursing issues. You can also check the video links, including one to: “Nurses Have Power: Let's Use It for Change.”

As Registered Nurses we continue to be a significant “caring” force in healthcare. We need to continue to be involved; to take advantage of opportunities through work, community and political involvement at local, state and national-and even international levels.

About the ANA Constituent Assembly: I continue as a member of the Executive Committee of the ANA Constituent Assembly (CA); the group of the Presidents and Executive Directors of all of the states plus a number of other constituents). We meet at least twice a year, sometimes “virtually” (via web technology). The CMAs also meet on calls with the ANA President. I shall keep you updated on issues that we address on behalf of ANA/C California, other states and ANA.

Thank you again, to our ANA/C California Board members and staff who persist on working hard, promoting quality healthcare for the public, participating in healthcare reform and supporting the Nursing profession and the association.

We invite you to plan to attend the following (please see our website):

- \* National Nursing Ethics Conference, Advocacy-Making a Difference for Patients, March 24th and 25th, 2011, by ANA and Ethics of Caring, at the Universal Hilton, Universal City, CA
- \* ANA/C RN Lobby Day, April 4th, 2011, in Sacramento, CA
- \* ANA/C General Assembly, Saturday, October 29th, 2011, at West Coast University, Ontario, CA

Please send us any comments, suggestions and questions.

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## ANA\California Wants To See You.... IN THE NEWS

Have you or one of your colleagues been recognized for an accomplishment, elected to office, won an award, received a grant or scholarship, launched a new venture? Tell us about it! Send name, address, phone number, and accomplishment—

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## Article Submittal to 'The Nursing Voice'

ANA\California accepts and encourages manuscripts and editorials be submitted for publication in the association's quarterly newsletter, *The Nursing Voice*. We will determine which letters and articles are printed by the availability of publication space and appropriateness of the material. When there is space available, ANAC members will be given first consideration for publication. We welcome signed letters of 300 words or less, typed and double spaced and articles of 1,500 words or less. Articles printed in *The Nursing Voice* do not necessarily reflect the views of ANAC, its membership, the board of directors or its staff.

ANA\California's official publication, 'The *Nursing Voice*' editorial guidelines and due dates for article submittal is as follows.

- Manuscripts should be word processed and double-spaced on one side of 8 ½ x 11 inch white paper. Manuscripts should be emailed to Editor at [TheNursingVoice@yahoo.com](mailto:TheNursingVoice@yahoo.com)
  - Manuscripts should include a cover page with the author's name, credentials, present position, address and telephone number. In case of multiple authors, list the names in order in which they should appear.
  - The *Nursing Voice* reserves one-time publication rights. Articles for reprint will be accepted if accompanied with written permission.
  - The *Nursing Voice* reserves the right to edit manuscripts to meet style and space limitations.
  - Manuscripts may be reviewed by the Editorial Staff.
  - Articles submitted by members' of ANAC will be given first consideration when there is an availability of space in the newsletter.
- Photographs should be of clear quality. Write the correct name(s) on the back of each photo. Photographs will be returned if accompanied by a self-addressed, stamped envelope. Mail photographs to: Samantha Hunter, Editor, The Nursing Voice c/o ANA\California, 1121 L Street Suite 409, Sacramento CA 95814. Or email photographs in jpeg format to [thenursingvoice@yahoo.com](mailto:thenursingvoice@yahoo.com)
- E-mail all narrative to [TheNursingVoice@yahoo.com](mailto:TheNursingVoice@yahoo.com)



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AN AFFILIATE OF THE AMERICAN NURSES ASSOCIATION

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# Does Magnet Make a Difference?

*Tricia Hunter*

I had the “opportunity” to have surgery in two magnet hospitals in San Diego since November. When I scheduled myself for surgery, I am sure I went through the same trepidation most operating room nurses go through before participating in the same arena we have worked in! We know too much!

I have also had the experience of dealing with family and friends in the hospital and most of those experiences have been good but I can tell stories as can probably everyone else.

My first experience was at Scripps Memorial where I had a laparoscopy for a Lap Band. My anxiety was telling because my blood pressure gave me away. Though this was only a 24 hour stay, I was impressed with the staffing ratios and the positive attitude of the staff starting with the admitting clerk who met us as we entered the system. Even the housekeepers introduced themselves. The nurses were responsive and seemed to enjoy their work. I believe the positive experience for the nurses in their workplace makes a positive experience for the patient.

I spent a longer hospital stay at Sharp Memorial Hospital and Sharp Memorial Orthopedic Rehabilitation Center. I had bilateral total knees done December 14, 2010. I was so impressed when I was contacted by Registered Nurses from the preoperative center for prescreening and admitting to the hospital. I also was contacted by a Orthopedic Clinical Nurse Specialist about the complete

hospital experience. Both these visits made my hospital admittance smooth and unstressful. My blood pressure was normal while waiting for surgery! The nurses, who provided my care in the hospital and the rehabilitation center were thorough, positive and caring. There was never an issue of someone being available to provide me with pain medication or getting out of the bed.

I have not had surgery in awhile, but a change I experienced with both hospitals was the operating room nurse introducing the whole surgical team when I was taken into the suite. The operating room nurse also came out to introduce herself in the preoperative area. The operating room can be scary for any patient, even one who knows what goes on. These two steps made my experience less stressful.

The staffing was appropriate at both hospitals. I never felt I was deserted as I have experience with family members in other hospitals. I never felt I was imposing on someone when I needed help or medication. A nurses aid at Sharp Orthopedic Rehabilitation “fit” me in for a shower on a busy day shift on the day I was going home. This type of concern, caring and help is something that cannot be fabricated. It was the atmosphere of the system and was really appreciated by this patient.

There is a lot of individual pride for a hospital to successfully be labeled a magnet hospital. It takes the whole team to make this happen. Congratulations to Sharp Memorial and Scripps Memorial for not only succeeding but making it a part of your culture.



# Regional Focus Groups on Health Workforce Development

## “Preparing the Health Workforce for Federal Health Care Reform”

### Background

Due to California's size, and the diversity of its geography and population, the accessibility and availability of health care services differs greatly from region to region. Because of these regional nuances, strategies to develop the health workforce needed in a given area must be based on a thorough understanding of the region, the characteristics of its population and the current make up of its health care delivery system. Additionally, the implementation of the Federal Patient Protection and Affordable Care Act (ACA) will profoundly change the health delivery system and in turn, will result in significant health workforce development needs.

To better understand these regional health care delivery systems, their related workforce development needs and how these will be affected by the implementation of the ACA, the California Workforce Investment Board (State Board) and the Office of Statewide Health Planning and Development (OSHPD) will be hosting nine regional meetings throughout California. Each regional meeting will offer leaders from the area opportunities to consider how the ACA will affect their region's health delivery systems, and discuss new models of care that would be beneficial to the region, the region's health workforce needs, the availability of education and training opportunities for health care occupations, and explore partnerships and priorities that are critical to ensure access to quality health care for the region's residents.

The State Board and OSHPD have engaged the Health Workforce Development Council (Council) to provide guidance and recommendations on the locations for regional focus groups which will be convened to gather information critical to the issues listed above. In addition to advising on the location of the focus groups, the Council provided input on the types of organizations to be invited, names of area leaders to include, and the structure of the questions to be asked during these sessions. Ultimately, the information and recommendations coming from the regional focus groups will be considered by the Council as it works to fulfill the expectations of the Health Workforce Planning Grant and begins to chart the path for workforce development planning associated with the implementation of the ACA in California.

### Objective

The State Board and OSHPD will convene a cross-section of healthcare stakeholders in nine areas throughout California. These meetings will be conducted as focus groups and will include employers, workforce development professionals, advocacy and professional associations, researchers, educators and regional leaders. The meetings constitute a beginning dialogue on regional workforce development challenges and opportunities presented by the ACA.

The regional focus groups will serve three primary functions:

- Learn from health care employers what the State can do assist them in training, recruiting, utilizing and retaining the quality health care workforce which will be required under the ACA.
- Assist the Health Workforce Development Council, the State Board, and OSHPD in fulfilling the planning objectives to be achieved under the HRSA-funded Health Workforce Planning Grant, and lay the ground work for the articulation of health workforce development strategies that can become part of California's implementation plan.
- Establish a foundation for, or enhance existing regional partnerships aimed at improving alignment of existing health workforce development activities and identifying new activities needed, particularly in response to the ACA
- Position California as a strong applicant for the federal Health Workforce Development Implementation Grant and to be a national leader in the implementation of ACA.

### Focus Groups Locations

Focus Groups will be held throughout the state in order to ensure a broad stakeholder group is tapped for insight. Nine general segments of the state have been identified as locations for the meetings.

Regional Area (Counties)	Meeting Date & Time	Location	Meeting Site
<b>Bay Area</b> (San Francisco, Marin, Solano, Contra Costa, Alameda, San Mateo, Santa Clara, Napa)	Wednesday February 2, 2011 9:30 a.m.-3:00 p.m.	Oakland	Hilton Oakland Airport 1 Hegenberger Road Oakland, CA 94621
<b>Lower Central Valley</b> (Kern, Inyo, Mono, Tulare, Kings, Fresno, Merced, Madera)	Thursday February 10, 2011 9:30 a.m.-3:00 p.m.	Fresno	Radisson Hotel & Conference Center 2233 Ventura Street Fresno, CA 93721
<b>Northeast</b> (Shasta, Tehama, Butte, Lassen, Del Norte, Modoc, Plumas, Sierra, Siskiyou, Tehama Trinity, Colusa, Glenn, Lake, Sutter, Yuba)	Tuesday February 15, 2011 9:30 a.m.-3:00 p.m.	Redding	Hilton Garden Inn 5050 Bechelli Lane Redding, CA 96002
<b>North Coast</b> (Humboldt, Mendocino, Sonoma)	Wednesday February 16, 2011 10:30 a.m.-4:00 p.m.	Ukiah	Hampton Inn Ukiah 1160 Airport Park Boulevard Ukiah, CA 95482 (707) 462-6555
<b>San Diego/Imperial</b>	Tuesday February 22, 2011 9:30 a.m.-3:00 p.m.	El Centro	Fairfield Inn & Suites Marriott 503 Danenburg Drive El Centro, CA 92243
<b>Central Coast</b> (Santa Cruz, Monterey, Santa Barbara, San Benito, San Luis Obispo, Ventura)	Tuesday March 1, 2011 9:30 a.m.-3:00 p.m.	Oxnard	Courtyard Oxnard Ventura 600 E Esplanade Drive Oxnard, CA 93036
<b>Los Angeles/Orange</b>	Wednesday March 2, 2011 9:30 a.m.-3:00 p.m.	Orange	Hilton Suites Anaheim 400 N State College Boulevard Orange, CA 92868
<b>Upper Central Valley</b> (Alpine, El Dorado, Nevada, Placer, Sacramento, Stanislaus, San Joaquin, Amador, Calaveras, Mariposa, Tuolumne, Yolo)	Tuesday March 8, 2011 9:30 a.m.-3:00 p.m.	Sacramento	Hilton Sacramento Arden West 2200 Harvard Street
<b>Inland Empire</b> (Riverside, San Bernardino)	Wednesday March 16, 2011 9:30 a.m.-3:00 p.m.	Ontario	Double Tree Ontario 222 North Vineyard Avenue Ontario, CA 91764

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*Regional Focus Groups continued from page 4*

Proposed Agenda

- 9:30 a.m.-10:00 a.m.—Event Registration and Table Assignments
- 10:00 a.m.-10:05 a.m.—Welcome and Introductory Remarks
- 10:05 a.m.-10:20 a.m.—Overview of the Health Workforce Development Council and California's Planning Grant
- 10:20 a.m.-10:30 a.m.—Overview of Focus Group Process and Ground Rules
- 10:30 a.m.-11:30 p.m.—Breakout Discussion: Focus Group Questions 1-3  
Each table will be given a specific question to address
- 11:30 a.m.-12:00 p.m.—Focus Group Table Report Outs
- 12:00 p.m.-12:45 p.m.—Lunch
- 12:45 p.m.-2:00 p.m.—Breakout Discussion: Focus Group Questions 4-6  
Each table will be given a specific question to address
- 2:00 p.m.-2:50 p.m.—Focus Group Table Report Outs
- 2:50 p.m.-3:00 p.m.—Closing Remarks

Regional Focus Group Questions

*Participants will be asked to provide their responses to the following questions. As they consider their responses, we are asking that, to the degree possible, they identify what actions the State could take to remove barriers, facilitate resolution to issues identified or consider other action that would ease transition to a new health care delivery model consistent with the ACA.*

- What is the most significant health workforce development challenge in this region? What are the biggest challenges that are unique to your region?
- In response to the ACA, what categories of primary and other health workers are needed immediately, within 2 years, and within 3-5 years?

- What resources are currently being invested or utilized in the region to recruit, educate, train or retain the health workforce (see sample matrix) and strengthen partnerships? Where is additional investment needed? How do you work with local workforce investment boards and one-stop career centers? Describe Federal, State, and Local policy changes that could be implemented that would aid in the recruitment, education, training, or retaining of the health workforce.
- What successful models of health professions education and training currently exist to supply the health workers necessary to improve health care in the region? What types of new models will be needed to meet the impact of ACA? Describe Federal, State, and Local policy changes that could be implemented that could facilitate new and successful models.
- What best practices and models exist to increase workforce diversity and to ensure that patients have access to care provided in a culturally and linguistically appropriate manner? What else is needed? Describe Federal, State, and Local policy changes that could be implemented to increase workforce diversity and to ensure that patients have access to care provided in a culturally and linguistically appropriate manner.
- What partnerships are you involved in or do you believe will be necessary at the state and regional level to meet the health workforce needs of this region? What actions are necessary to strengthen existing partnerships and/or form new partnerships?

# BRN Administrative Meeting

*BRN Meeting  
February 2, 2011  
Santa Ana*

The first business of the board was to take nominations for the position of Vice President. Doug Hoffner, a new board member appointed by Governor Schwarzenegger, was elected. Doug's background was working for the legislature and a staffer in the Governor's office.

## The Executive Director reported on the following subjects:

Darlene Bradley, RN, PhD(c), MSN, MAOM, CNS, CCRN, CEN, MICN, FAEN has been appointed as the new Nurse Administrator on the Board of Nursing. She is the Director of Emergency Services at UCI Medical Center, Orange County. She has been active in the Emergency Room Nurses Association including President of California and has received numerous awards.

**Budget:** The board is requesting total augmentation of 2.6 million for the Attorney General line and 288,000 for the Office of Administrative Hearings.

**DCA:** Kimberly Kirchmeyer, Deputy Director for Board/Bureau Relations has been asked to serve as Acting Chief Deputy Director. LaVonne Powell, Senior Staff Counsel has been asked to join the executive office and serve as Senior Advisor to the Director.

The **Executive Order** to reduce cell phones has reduced cell phones by the BRN by 50%. The BRN is expected to move into their new facilities

**Sunset Hearing** has been set for March 14 Senate Business and Professions Economic Committee.

**Hiring Freeze:** The Governor's Office has directed all state agencies to continue to cease all new hires that include filling vacancies, promotions, hiring temporary help and board appointments. At this time, the board has 47 vacancies, 36 CPEI positions and 11 non-CEPI positions. The board continues to advertise for the positions in hopes of filling them.

I addressed the board about my concern that the Budget hearings are not addressing the extreme shortage of personal at the board and this has affected their ability to protect the public.

**\*Enforcement Regulation:** The enforcement regulations are posted on the BRN website. A public hearing is scheduled for March 3, 2011 at 10:00a.m. Written testimony is just as important as attending the hearing. Please look at these regulations.

## APRN Survey Update:

The BRN is working with the UCSF Center for Health Professions to complete a survey of Nurse Practitioners, Nurse Mid-Midwives, and Clinical Nurse Specialists. The survey was sent to 2,250 NP's and Nurse Mid-Wives, and 750 CNS's. The response rate was 60% from NP's and CNM's and 70% from CNS's. The final report should be done by June 2011.

## Public Records Request:

There were 77 public record requests from November 2010 through January 21, 2011. In January, a TV station in Sacramento requested information about any promotional items purchased. The BRN has purchased none. There will probably be a story soon.

## Bill Steiger, Director of Consumer Affairs

Bill updated the Board on the staff of the Department of Consumer Affairs. He informed the Board that currently, there is no agency secretary or deputy secretary on staff.

He addressed the hiring freeze. He stated the hiring freeze stopped when Governor Brown came into office. The Department is choosing to continue its hiring freeze to give the Brown Administration a chance to understand the issues that affect BRN board. He stated they are going to go through an exemption process. They have over 600 vacancies throughout the DCA. Unfortunately this does not resolve the fact that the board does not have the ability to fulfill their responsibility to protect the public.

## Administrative Committee

A discussion occurred regarding the BRN going paperless and using computers with jump drives or discs to receive the information for the hearings. The Executive Officer Louise Bailey will do some research with other state nursing boards on the implementation process.

## Legislative Committee

### AB 30 Hayashi Violence in Hospitals

(CNA Sponsor) ANA\IC Support

The AB 30 bill deals with safety issues in the workplace. The bill requires a safety health plan and the nurse to be treated if involved in an incident. The bill states a hospital cannot take retaliatory action against a nurse if she seeks emergency help and/or calls the law enforcement. The bill requires a reporting process to DHS within 48 hours of the incident. It establishes a reporting process to the legislature concerning violence in hospitals. The BRN voted to support the bill.

### AB 40 Navato Elder Abuse Reporting

The BRN moved to take a watch position.

### SB 65 Strickland Prescriptive Pancreatic Enzymes

The BRN believes an existing law already allows the assistance but there may be issues around "other designated persons" and allowing the student to carry the enzymes on campus. The enzyme is a digestive system aid and does not have hemodynamic affects.

The BRN moved to watch.

### SB 100 Price Board Advertisement

This bill would require the license designation to be listed first after a person's name. It also deals with laser treatments and supervision.

The BRN voted to Watch

## Omnibus Bill

BRN submitted Section 2736.5 to delete the word experience with evaluation of medical corps of armed forces. The BRN reviews education not experience so the word does not apply.

Section 2770.7 This section establishes criteria concerning a registered nurse for acceptance, denial or termination of registered nurses in program. The BRN added " unless the nurse is accepted into the diversion program and is successful in the program...."

Section 2786(b) Approval of Schools

Changes encourage to require all schools to provide clinical instruction in all phases of the educational instruction.

In sunset review they are considering to have the board approve the program and the right to confer the degree so this is being held at this time....

Section 2836.2

This section corrects an error that sites a nonexistence code section. It was a typing error. This one is accepted.

## Experts

Language is being prepared for all boards to exempt the experts from the contract process. The Medical Board proposed the language but DCA is proposing it for all health care boards.

The BRN voted to watch.

## Diversion Discipline Committee

Nursys Discipline Data Comparison (Scrub) Update

262 Cases have been referred to the Attorney General

215 Pleadings have been received

118 Notices of Defense received

47 Referred to Site and Fine

450 Closed without action (Action taken in CA but not in Nursys database)

Cost of Nursys scrub so far is 293,210.00 (average 58,642.00 a month)

## Internet Disclosure Policy

There was a discussion by the board about whether there should be a policy to remove discipline information from the website after a certain length of time. The medical board removes discipline information after 10 years.

## Implementation of Uniform Standards relating to Substance Abuse and Disciplinary Guidelines

The attorney proposed that the BRN promulgate regulations as described by the DCA department related to the objection from public testimony at the committee hearings concerning the frequency of mandatory drug testing. The testimony at the committee level was concerned that the mandatory drug testing requirement would end our probation and diversion program. The individual participant must pay for their testing. At a cost of 600 to 1000 dollars per test, the mandatory testing proposed would end the ability of many nurses to afford the program. Additionally, there would be no random testing because the testing was so frequent.

**BRN Administrative Meeting continued on page 7**

The attorney proposed a compromise submitting two sets of language so the BRN can submit regulatory language before the sunset hearing. ANA/C expressed concern about the testimony given at numerous Diversion/Discipline Committees was not being included in the proposed language.

ANA/C is strongly supportive of the Board's wish to implement regulations that work for nurses and was assured by the Department and the Board that language would be developed to address the concerns expressed.

#### **Education Committee**

A summary of the 2009-2010 Education Survey was shared.

The Board approved all the minor and major curriculum changes.

The Board approved having informational hearing on accreditation of nursing programs. There will probably be four of them held throughout the state.

There was a report about the problems the NEC's are encountering with applicants for licensure. They found a number of programs that state they are granting a nursing degree in another country but the student never goes to that country even though it states they took clinical there. There are problems with the equivalencies these schools are accepting and the looseness in evaluating the prerequisites. The following is a summary of issues with Out of Country Applicants that take a lot of the BRN staff time.

#### **Issues:**

The International Analysts have seen an increase in the number of fraudulent documents. These documents include transcripts allegedly being sent from nursing schools and copies of registered nursing licenses sent by applicants. While the number of applications has decreased, the time needed to analyze the applications and supporting documents has increased.

The BRN is concerned with online nursing programs that offer degrees based on life and/or work experience. The applicant can earn a degree in as little as seven (7) days. The websites state that there is no attendance required, no course materials, no examinations, and no waiting to get into the program.

#### **Out of Country Applicants:**

#### **Issues:**

While the Licensing Program has experienced a decrease in the number of applications for applicants educated out of the country, the level of difficulty in analyzing these applications has increased.

The Licensing Analysts review documents from nursing programs all over the world. While the documents differ in format from each country, there are consistencies within each country. The following is a sample of some of the difficulties the Licensing Analysts deal with on a daily basis.

#### **Philippines**

There are "blended" programs where applicants complete the theoretical portion of the program online and then

travel to the Philippines to complete the clinical portion. Theoretical course work and clinical practice are not taken concurrently, as required by California Code of Regulations section 1426(d).

Questionable nursing licenses have been received. The staff accesses the Professional Regulations Commission (PRC) in the Philippines to determine if the applicant took the nursing examination. The BRN also receives information from the PRC as to the latest license number issued and can determine if the license received begins with a number that has not been issued. Questionable transcripts have been received that look similar to those from a traditional four-year program. Staff corresponds with nursing programs to verify if the applicant attended the specific program and received a degree.

#### **Haiti**

Documents received from the nursing schools are questionable. The Licensing Analysts have received curricula from three different schools; however, all course descriptions, student's grades and the number of theoretical and clinical practice hours are identical, no matter when the student attended the program. The BRN cannot obtain official documentation from the Ministry of Public Health and Population to verify approved nursing schools in the country.

#### **Ethiopia**

Until recently, staff was not aware of different levels of nursing programs in Ethiopia. These programs are Junior Clinical Nurse or Clinical Nurse which is an occupational title for a lower level nurse. The staff is attempting to obtain clarification of these programs from the Ministry.

#### **Nigeria**

Within the last year, the Board has received diplomas from nurses educated in Nigeria. Up until that time, the Board only received licenses from nurses. The BRN is attempting to obtain clarification from the Ministry in Nigeria as to why it is no longer receiving licenses.

#### **Russia and former Republics**

There are questions regarding the programs in general. Transcripts are not presented in semesters or quarters per year. When a program curriculum is requested, the documents received do not provide detailed descriptions of the course work. Applicants must complete State Examinations at the end of the program. The BRN received confirmation from the Ministry of Health that Obstetrics is not a State Examination required for nursing students. However, no matter when a student completed the nursing program, this is one of the State Examinations each graduate has completed.

#### **China**

There are concerns regarding theoretical and clinical practice. In some programs, the student completes the majority of their clinical practice in the third year, with only minimal clinical training in the first two years. This is a concurrency issue.

## **Announcement**

ANA/C Elections were held this year and the new officers took their positions at the March Board Meeting in Sacramento, California.

#### **PRESIDENT**

Elissa Brown, MSN, PMHCNS-BC, RN

#### **VICE PRESIDENT**

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Angela Schwab BSN, RN

#### **Director of Legislative and Professional Advocacy**

Monica L. Weisbrich BSN, RN

#### **Director of Education**

Dianne S. Moore PhD, MPH, CNM, RN

# The National Council of State Boards of Nursing APRN Summit

**Dianne Moore**  
**Elissa Brown**

The National Council of State Boards of Nursing (NCSBN) held an APRN Summit on January 12 and 13, 2011.

The agenda was as follows:

1/12/11

**Understanding the APRN Consensus Model**—Ann O'Sullivan

**Future of Nursing IOM Call to Action**—Catherine Dower

**Scope of Practice- Toolkit for Consumers**—David Swanklin

**Building a Coalition of Support/Plan of Action**—Maryann Alexander

**Passing Legislation: An Insider's View**—Melvin Neufeld

**A Lobbyist Perspective**—Sue Clark

**LACE Update**—Joan Stanley

1/13/11

**APRN Consensus Model for Regulation and Health Reform**—Peggy Welch

**APRN Legislative Success Panel**—Charlotte Beason, Mathew Bishop, Emmaline Woodson, Shirley Devaris

**Moving Forward: Challenges and Opportunities**—Kathryn Busby, Gregory Harris, Elaine Germano, Kelly Goudreau, Tay Kopanos, John Preston, Susan Reinhard

**Campaign Resources**—Stephanie Fullmer

**Closing remarks**—Ann O'Sullivan

Please see: <https://www.ncsbn.org/2383.htm>—video which describes the NCSBN position on the Consensus model for Advanced Practice Registered Nursing (APRN).

On the Q drive under the folder for MSN DNP there is a subfolder entitled NCSBN Consensus model. In that folder

there are a number of different resources that discuss the legislation, accreditation, certification and education for the advanced practice nurse. These regulatory items are running parallel to the AACN DNP Essentials and complement each other.

Basically the model of the pyramid for the educational model is exactly what is being subscribed to on all fronts.

The 3 P's—physiology, pharmacology and physical assessment are all required for the APRN role.

The simplicity of the course descriptions as provided in the curriculum model offered by NONPF (National Organization of Nurse Practitioner Faculty) was requested by NCSBN so transcripts from one school to the next or for certification and licensing are easy for the student and group that are reviewing transcripts to understand. WCU's curriculum model follows all those recommendations.

The presentation on the IOM Future of Nursing report focused on using the NCSBN consensus model to change state regulations to allow RN's and APRN's to function at their full capacity. The IOM intends to be aggressive in pushing for change and one of the 5 states being specifically targeted for legislative change is California. There are state and national committees being formed to address the strategies for the change. The NCSBN provided tool kits to help with planning and implementing these changes (see website and our Q drive). There were two ANA\ C BOD members at the meeting (Elissa Brown —ANA\ C President and Dianne Moore the ANA\ C Director of Education), and other ANA\ C members, including LuAnn Sanderson, Secretary, CAPNAP, 1 BRN Board member and the EO and the NEC from the BRN also present. They were generally supportive of the model, with some concerns voiced.

The other presenters were legislators, lobbyists, consumer groups and examples of states and other Boards of Nursing that had been successful in changing the APRN scope of practice laws. The NCSBN has developed a toolkit to help states, organizations, students and others to be one strong voice in helping change occur. Please see the documents

located on the Q drive MSN DNP folder subfolder NCSBN Consensus model for more details, the video and the PowerPoint.

The other change that many APRN will have to adjust to is the population foci that will be certified and licensed. As with the pyramid model the base is the 3 P's, then the other courses related to the advanced role as is evidenced in the MSN and DNP AACN Essentials, then the 4 APRN roles of CRNA, CNM, CNP and CNS. The population foci will be the Family/Individual across the lifespan, adult gerontology, women's health/gender roles, neonatal, pediatrics, psych/mental health. Examples of the subspecialties would be. *Oncology, Older Adults, Orthopedics, Nephrology, Palliative Care* or others like the perioperative. The license will be based on the 4 APRN roles and 6 population foci such as family, mental health, adult etc. The WCU curriculum is set up to address the students learning in just such a pathway for the programs accreditation, the student's certification and licensure (LACE).

There are some concerns that were voiced by the Clinical Nurse Specialist group, in re to maintaining the specialty essence of the CNS role. There was a report that 2 psychiatric nursing organizations had made some controversial proposals about the future of the Psychiatry\ Mental Health CNS.

There were two specialty areas that do not fit the neat definition or current language for the APRN, namely the CNM and the CRNA. For the CNM there is a complicated history including that midwifery is a separate profession from nursing as is recognized by the rest of the world (the US version of only having a CNM is the outlier and that is changing with the advent of the CM (Certified Midwife) and CPM (Certified Practicing Midwife)). The other is the CRNA partly because of the fact that of the 3000 students produced each year, 42% of the 110 schools are not in nursing programs so both the CRNA and the CNM asked that the wording regarding the educational pathways be carefully considered so they are not excluded.

# NCSBN Embarks on an Innovative Multi-Site Transition to Practice Study to Examine the Effects of Nurse Transition to Practice Programs on Patient Outcomes

Chicago—The National Council of State Boards of Nursing (NCSBN®) ([www.ncsbn.org](http://www.ncsbn.org)) announces the launch of an innovative, multi-state study to evaluate safety and quality outcomes in nurse transition to practice programs. In addition, the study will determine how well the preceptor training module prepares preceptors for their role; identify the challenges and potential solutions of implementing the NCSBN transition model; and determine cost/benefit analysis.

NCSBN has brought together a research advisory panel of nationally renowned experts with extensive backgrounds and experiences studying new nurses and entry into practice. The panel was convened to assist NCSBN in the planning of the study and will continue to share their expertise throughout the implementation and analysis of the study.

During Phase I, the NCSBN Transition to Practice Study will follow newly licensed registered nurses (RNs) hired to work in hospital settings in Illinois, Ohio and North Carolina during their first year of employment. Phase II will include newly hired RNs who work in settings other than hospitals and licensed practical/vocational nurses (LPN/VNs) who work in all health care settings. Throughout the year the newly hired nurses will participate in interactive, online transition to practice modules, work one-on-one with a preceptor and receive institutional support from their hospital.

“NCSBN has been working on transition to practice for more than 10 years,” said Maryann Alexander, PhD, RN, chief officer, Nursing Regulation, NCSBN. “Evidence shows that transition to practice programs protect patients and the public, which is the very mission of state boards of nursing and NCSBN. We are excited to embark on this study and the data collected will have a great impact on the future of nursing after initial licensure.”

This study is unique in two ways. First, it is the only transition study where sites will be randomly assigned to either a standardized transition to practice model or to a control group. The use of a control group will allow NCSBN to statistically analyze differences between study and control groups. Secondly, this study is the first to analyze actual patient outcomes in programs that transition new nurses to practice. Other studies of transition programs have looked at retention rates, new nurse satisfaction, preceptor satisfaction, and nurse’s perceptions of competence and confidence, but they haven’t examined actual patient outcomes. Since NCSBN’s transition to practice program is a regulatory model, it is essential to evaluate patient outcomes.

Each site in Illinois, Ohio and North Carolina will be randomized to either the study group or the control group. The control group will use its usual practice of transitioning new nurses to practice. The study group will participate in NCSBN’s Transition to Practice Model. Newly licensed nurses in this group will successfully complete five interactive, online modules within their first three months of employment. The modules include patient-centered care, communication and teamwork, evidence-based practice, quality improvement, and informatics. These modules are designed to integrate experiential and active learning, and will not incorporate relearning of content that the new nurses have already learned in their nursing programs.

In addition to the modules, newly hired nurses will be given a preceptor to work with during their first six months of employment. The preceptor will be required to complete NCSBN’s online preceptor training module. During the final six months of their involvement in the study, the newly hired nurses will receive institutional support. This

may include being invited to serve on committees that look at the root cause of an error or creating procedures that allow the new nurse to be given continuous feedback and evaluation. By providing institutional support, nurses are encouraged to reflect upon the care they have provided and to suggest quality improvements.

Site coordinators at each hospital will submit data electronically to study researchers at NCSBN. The data collected will measure actual patient outcomes such as infection rates, patient falls, patient satisfaction, as well as new nurse competencies, job satisfaction and job stress, to name a few. Once Phases I and II of the study have concluded, statisticians will compare safety and quality outcomes of the control group with those of the study group.

The final report of the NCSBN Transition to Practice Study will be reviewed by the NCSBN Board of Directors (BOD) in May 2014. Based on the results, the NCSBN BOD may recommend adoption of the NCSBN Transition to Practice Model to the NCSBN Delegate Assembly.

*The National Council of State Boards of Nursing (NCSBN) is a not-for-profit organization whose members include the boards of nursing in the 50 states, the District of Columbia and four U.S. territories—American Samoa, Guam, Northern Mariana Islands and the Virgin Islands. There are also seven associate members.*

*Mission: NCSBN provides education, service and research through collaborative leadership to promote regulatory excellence for patient safety and public protection.*

*The statements and opinions expressed are those of NCSBN and not the individual member state or territorial boards of nursing.*

## NCSBN Selects States for a Longitudinal Study of Transition to Practice in Nursing

Congratulations to Illinois, North Carolina and Ohio! These states have been selected to participate in NCSBN's groundbreaking study of a standardized transition to practice program for newly licensed nurses. Michele Bromberg, Nursing Coordinator of the Illinois Board of Nursing says, "Illinois has been exploring the need for transition programs, so we are excited to be one of three states selected to participate in NCSBN's landmark transition to practice study."

These three states mounted enormous statewide efforts to identify 75 hospitals for phase I of the study. Phase II will include long-term care, community, and home health sites. This is the first study of a transition program to

The logo for "Transition to Practice" features the words "Transition" and "Practice" in a serif font, with "to" in a smaller font between them. A blue circular arrow graphic surrounds the text.

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compare patient outcomes in sites that use a standardized transition model to those that don't.

NCSBN is in the process of hiring a state coordinator for each of these states. A kick-off meeting for the study is being planned for April 27-28, 2011, in Chicago for the state and site coordinators. Stay tuned for more information on this multi-site study!

# Association of California Nurse Leaders (ACNL) Hold Annual Meeting

ACNL held their 33rd annual meeting February 13-16, 2011 at the Sacramento California Convention Center. Board Member Monica Weisbrich, RN attended the convention with webmaster and member, Suzanne, Ward, RN. The theme for the year's conference was *California Dreamin'*. The President's Reception, *A California Vintage Family Affair*, held Sunday evening honored B.J. Bartleson, ACNL President. Accolades were presented by Family (husband and children), work Family (The Shriners Hospital for Children No. Cal family), the CHA Family (Dorel Harms—ACNL liaison), AONE Family (Richard Brock, ACNL past President) and the Stryker Family (Jim Wilcox, Regional Manager). Then the networking began.

## KEYNOTE SPEAKER—*SUNRISE OVER THE SIERRA*

Selinza Mitchell, RN was the keynote speaker who presented an over the top opening for the Conference. The message sent to and received by the attendees was *How are you doing?* Mitchell re-energized the attendees and opened our eyes to the difference we make in the lives of others.

## GENERAL SESSION *SCALING EL CAPITAN*

Jayne Felgen, MPA, RN, author of *I2E2 Leading Lasting Change*, shared her in-depth, yet simple formula for inspiring and leading real change at all levels of any organization. The five primary components are Vision, Inspiration, Infrastructure, Education and Evidence.

## GENERAL SESSION *CASH CROP*

Andre Delbecq, DBA, Santa Clara University states managing change is the primary organizational challenge facing health systems today. We are asked to *improve quality at a lower price point*. Innovation will be required to deal with the increased pace of change facing health system today. Innovation barriers identified are:

- Centralized planning—*There is no success story associated with centralization.*
- Vested interest in present programs
- Inadequate slack resources

Searching for behaviors is more important than brilliance. The way for innovation to work/advances is *I've got a hunch. I'd like to try.*

## ISSUES FORUM—*NEWS FROM TELEGRAPH HILL*

Three presenters—Pat McFarland, RN, Dorel Harms, RN, and Louise Bailey, RN presented status reports for the ACNL, CHA and BRN. Major issues discussed:

- Institute of Medicine (IOM) eight recommendations and the formation of the Regional Action Coalition (RAC).
- CA budget—\$26.5 billion deficit. Major contributors to the deficit are lower income because of lack of housing starts/foreclosures and unemployment. Both impact tax bases in the State
- Budget assumptions—CA budget passed by 3/30/11,

Federal budget approved on time, necessary cuts implemented by 10/1/11.

- Percentage of cuts to Medical/DPSNF, physicians, pharmacy (drugs), Medical Clinics, Home Health and Medical transport were reported. As I write this report for ANAIC (2/17/11), the proposed cuts have been either changed or deleted. This is a wait and see issue.
- Bottom line—Which ever way the cuts go, patient mix will decide the impact on individual hospitals/health systems.
- Legislation—the beginning of a two (2) year cycle brings:
  - CNA Wish List (single payer)
  - Consumer Unions Wish List (transparency for peer review)
  - MICRA—(pain and suffering cap of 250K)
  - Privacy—legislators want more privacy
  - Interpreters—re-introducing a bill already in regulation requiring translator for the major languages in every hospital
  - Pharmaceutical Repackaging
  - Hospital Accreditation—may be accredited by other accrediting bodies rather than JCAHO.
  - BRN—Bailey presented an extensive review of the services/activities offered by the BRN including education, practice, legislative and diversity. Stats from each committee were shared

## GENERAL SESSION *RIDING THE WAVES OF CHANGE*

Dan Gross, DNSc, RN Executive Vice President of Sharp Health Care shared the latest developments and analysis of the Health Care Reform (HCR) as it moves forward in the implementation phases. Throughout the process Gross emphasized *If you are not at the table, you are on the menu*. The Theme of the HCR is:

- More people will be insured and access to care increased with lower reimbursement.
- The cost of care will be lower but the care will be excellent.
- There will be a move from fee for service to pay for outcomes.
- Cost shifting from Medicare/Medical no longer will be accepted by insurers.
- *Beat the Cost Curve*
- Form Accountable Care Organizations (ACO) [a lawyer/consultant's dream come true]—increase prevention thus lowering cost.
- ACO is really managed care (nomenclature is unacceptable to the general public).
- Two types of ACO's—senior and commercial (not in place yet)
- Center for Medicare/Medical Innovation (CMMI) will be formed.

- Care Continuation Systems—healthcare systems will partner with community clinics
- Bundling of Medicare Part A and B for ortho and cardiac
- Value-base Purchasing—there is enough data to identify 17 process measures. Largest cuts to be implemented to pay for increased costs for Medical population increases will be:
  - Lower Medicare payments
  - Increase taxes from those earning more than 250K/year
  - Increase taxes for:
    - Commercial insurance companies (Blue Cross/Aetna, etc.)
    - Drug manufacturers
    - Medical Devices (e.g. implants).

## GENERAL SESSION *NEW FRONTIER*

Heather Young, PhD, RN, FAAN, Casey Shillman, PhD, RN and Debbie Ward, PhD, RN, FAAN formed a panel to discuss the IOM history, the RAC implementation process which was then followed by open discussion.

Heather Young reviewed the history of the IOM study, described the process the IOM used to arrive at the 8 nursing recommendations (a process funded by the RWJ Foundation and AARP).

Casey Shillman discussed the purpose of the RAC—To engage diverse stakeholders in the Initiative for the Future of Nursing (IFN) and build visibility within the community at large. The message to be carried is *improving health systems and the health of our communities through nursing.*

## GENERAL SESSION *CALIFORNIA MISSIONS*

Barbara Bates-Jensen, PhD, RN described the challenges and triumphs in providing disaster relief in Haiti. Bates-Jensen's area for expertise is wound care. Experts in this field were specifically requested. Disasters of this nature call for crises-management and altered standards of care requiring decision-making skills not used in daily operations.

**POSTER SESSIONS**—There were 14 poster sessions provided for viewing on Tuesday.

## FOOTSTEPS OF FLORENCE NIGHTINGALE

A presentation by four ACNL members trek to England to celebrate Florence Nightingale's legacy and tract key events in her life was very moving and validated one's love of the profession. This event was a fundraiser for Flo's Cookie Jar. Flo's Cookie Jar is a program that provides emergency funds for nursing students in financial crisis. This funds pays the rent, fixes a car, or helps in other emergencies.

The 34th Annual ACNL Conference  
February 5-8, 2012  
Westin Hotel and Spa Mission Hills  
Rancho Mirage, CA

# India Trip

Myrna Allen, MSN, RN

I left for a medical mission trip to India with the Smile Train Foundation from December 3-16th. Our group consisted of an Anesthesiologist (Scottsdale, AZ), a Surgeon (Pittsburgh, PA), a retired surgeon who coordinated the trip and his wife (San Diego, CA), and me (Sacramento, CA) as the peri-operative nurse. The mission site was on the eastern shore of India within two miles of the Bay of Bengal, near the rural villages of Yanuguvanianka or Narsapur or Antervedi, in the rural state of Andhra Pradesh. India is comprised of forty (40) plus "state" territories.

The trip was long—first leg was 16 hours from LAX to Dubai—two hour lay-over—then a 4 hour flight to Hyderabad, India—then a four hour lay-over to go through Customs—then a 2 hour flight to Rahmundry—then a three hour car ride (dodging monkeys, water buffaloes, ox carts, and humans on scooters on one lane roads) for fifty miles to the mission over very rutted roads. Everybody uses their horn—this lets all know where you are on the road—one stretch our driver honked forty times in one minute—we counted. We all felt like road kill when we arrived at the mission.

However, the patients and their families were waiting for us upon our arrival. The patients came with the full family—mother/father/siblings/grandparents. One family came 200 miles including three bus changes. We started unpacking and assessing patients right away. Otherwise, I think we would have just stopped altogether due to fatigue. The weather was very warm 85+ with high humidity. This was India's winter season and the monsoons were over. Many of these patients did look like what you see in the magazines that show cleft lips and cleft palates and their deformities were severe. Our Indian physician contact had pre-screened many patients whom he thought would fit our criteria for corrective surgery. This included a good health assessment and the patient/family's ability to comply for follow-up care after surgery, a 30-day post-op mission visit and again a repeat visit at 90-days. Our littlest child was 8 months old and our oldest was 31—most of the patients were between 2 and 13 years of age.

The prevalence of cleft lip/palate in India is about 1 in 350 while in the USA it is about 1 in 10,000 or less...per our surgeon. (I have not confirmed this statistic.) As an aside, in the US when a baby is born with a cleft lip, it is usually repaired within the month of birth if not at birth. The cleft palate is almost always repaired by the 18-month mark, if not sooner, to enable proper speech. In CA these conditions are included as something the state covers under CA Children Services (CCS) regardless of the patient's ability to pay.



**This little girl had a huge cleft palate in addition to her cleft lip. We were able to close both defects. Her defects were the mildest we repaired.**

We left on Thursday (the 3rd) and arrived at the mission on Sunday (the 5th) afternoon. We had hoped to start surgeries the next day, but there were too many issues with the anesthesia/sterilizer set ups for this to happen. The portable gas tanks leaked, gas valves would not stay primed or shut, the anesthesia machine itself needed extra tubing and soda lime/etc and the sterilizer needed water hook-ups and testing. We had to send to Rahmundry for the needed supplies—which was a 12-hour turn-around trip once an item was requested. We started on Tuesday and worked until 10PM. We averaged 3-4 cases each day—starting at 8AM and finishing around 8PM each night. Due to the severe deformities, the cases were long. Also, not being completely sure of the hired staff's abilities for post-op care, we made sure the patients were fully awake before going to recovery for the overnight stay.

The hospital had not been a functioning hospital in four years and no on-going patients in the last two years. The hospital had a lovely obstetric set-up plus a surgical suite with an operating microscope that had been used for eye surgeries. Other volunteer groups had been to the mission, but never longer than a day or two. This was an extremely poor rural area, the patients could not pay, and the local physicians did not want to participate without payment or stipend. The custom in this part of rural India is for the doctor to build his own hospital and to live on the top floor and have only paying patients. Most people in this area lived on \$60-\$100/month max or about \$2/day or less.

The mission director (a teacher) and one local physician were in charge of getting the hospital ready prior to our arrival. They both did a great job but without a peri-operative background or knowledge base on what was needed for the surgical suites, there were issues. Equate it to sending yourself to NASA to prepare for a moon landing within a day. The hospital lay-out was perfect for patient flow. However, without



**The Registered Nurses from India who helped our group wearing their everyday working saris.**

permanent hospital staff, nobody knew how to turn on the water, turn on the lights, check the anesthesia tanks/lines, or operate the sterilizer, or work the back-up generator. The mission had hired four registered nurses from the city plus the mission nurse to help me set-up the operating room, the recovery area, and all of the needed support services to keep everything flowing. The mission director had also hired a very capable bio-med technician that was invaluable to keep our equipment working.

To start, we washed the walls of the OR with bleach and then each day my staff nurse used formaldehyde on all flat surfaces each morning. (Yes, my eyes stung for the first few minutes each day when entering the suite but it was all that was available.) Then we tackled the autoclave to ensure that it worked properly and that our instruments would be sterilized properly. I set up a team to wash and clean instruments and showed them how to wrap the instrument trays for each day's use. We could only run the autoclave once a day. Therefore, we worked from one sterile back-table and then changed the Mayo tray set-ups per each case. The mission nurse who worked with me had worked in the city for a plastic surgeon and she was just great. Her husband ran the little "pill" pharmacy for the mission school. We had brought eleven suitcases (each weighing exactly 50 lbs) with our supplies. Also, we had written before hand with all of the drug/IV solutions needs to do the cases and they had these things available. Otherwise, we were self-contained.

We had to find light bulbs, fuses, linens (there were none—the family brought sheet/pillow and the OR scavenged the instrument cloth wraps for the table/patient needs/shoulder rolls/head dough nuts, etc. I took the wheels off of a gurney to make a back table (have wrench will travel plus duct tape and pliers) but I did have a Mayo stand!!!!. The OR table was older than most with lots of cranks to turn. I had to set up a recovery room as all I had was a bed in a room without water, no linens, no monitors, etc. I did a crash course to the hired nurses (4) on how to manage an airway and how to use a suction and how the monitors worked (BP, pulse, EKG, pulse ox, etc)...all equipment that we had brought with us. We also had trouble keeping the electricity going and the lights on plus the suction working. The staff finally got the back-up generator working, but when the lights went out, nothing happened for one minute until it kicked in. That can be dangerous during surgery. We had back-up flashlights everywhere. It really brought back into focus all of the basic "basics" I learned a long time ago.

The staff were eager to learn and to help. I was able to be the first assistant on a third of the cases. It was just the surgeon and myself which was just great from my perspective. The rest of the time we had a female dentist and a "just graduated" female medical doctor—they were cousins—who helped as assistants for surgical suctioning and stitching. The medical doctor was the school's shining star as she was the first graduate of the mission school. She had gone to China for medical school where she said everything was taught in English. Unfortunately, she was not planning on staying in the area and was seeking to come to the US for her residency.

The most interesting thing is that **everyone** went barefoot. In the OR if the staff were not barefoot, they wore flip-flops with all other shoes (mainly black flip flops) left in the main hallway. One really had to watch for the shoes when going in/out of doors. When I got there I had not unpacked the shoe covers yet—so I was running around like the staff. Then the mission nurse had me stand on a piece of paper to measure/draw my feet and then wanted to know what size were the surgeons' feet. She was going to get flip flops for them, too. I communicated that was not what we were going to do. The language barrier was there but there was enough English understanding on the staff's part to make it work. I was either called "sister or madam" or "Myrna, come" or Myrna, come now" depending upon the situation. The staff would talk with me first before they would direct questions to the doctors. Culturally, everyone had a custom of **horizontal** head nodding when you spoke to them after which they rolled their eyes. If you asked for something, the answer was "yes" but then you had to put the action verb with it... "I need more sponges"..."yes"...please go get them now." This happened at all levels each and every time. Our group learned that with

English as the second language, the noun is picked out much quicker than the action verb. We had a learning curve, too. However, with hand signals, language was not a barrier.

We did post-op rounds in the morning prior to surgery. The hired staff nurses would talk to me, so I went with the doctors and via the staff nurses we communicated to the family the follow-up care needs. Many of the little ones did not wear diapers due to money issues but the parents changed the baby's clothes as needed when they became soiled. We had one child in a full parka with fleece lining in 90 degree weather. The family did not want us to know that they could not provide appropriate clothing so they had borrowed what they thought we would recognize as "winter" clothing since it was their winter season. I communicated to the family via the staff nurse that this was not needed, took the clothes off the baby, and covered her lightly with the family's sheet and gave the "ok" sign. Another family had been asked if the baby had urinated. The family adamantly said she had not, which we found hard to believe as the baby was eating and drinking. So I asked the staff nurse to ask the family if they had changed her clothing during the night—which had occurred four times during the night. The baby was discharged. At another time, we had a baby that was just "fussy" and the baby was 10-months old. After looking at the surgical site, I suggested that perhaps the baby was cutting a tooth (Moms know that fussy cry!) and low and behold—a tooth emerged. In the pre-op, we did a full assessment but many times the parents told us that their child had no health issues. Sometimes by holding the child you could ascertain fevers, lung rales, and other deformities. The family's main concern was that the child would be denied care if the baby was deemed "unhealthy." Without our intervention, the child would have a very difficult future in India.

Our accommodations were right next to the hospital and they were more than adequate as compared to the local area. However, we had no hot water for the duration. Our rooms were clean and we were safe as they had walking security while we were there. We slept on a plain mattress and had only one sheet and two rock hard pillows, but we all slept well. We had our own cook—which was vital for our health—and lots of bottled water. There was no TV, no radio, the wireless did not work (used my cell phone), or any newspapers.

The Hindu temple was right next door to the mission and the chants started at 4:30 each morning and blared quite loudly. Less than 10% of the population is Christian and there is much discrimination if you are one—you will be last to get a job, last to receive/buy any food in the open market, and last for just about everything else. We had "vespers" each morning at 7:30. We did post-op visits at 6:30 and went to the OR at 7:00 and then out to church (in the hospital) just for our group of five. Since it was the Christmas season, during one morning's vespers, the Christian minister (Tibetan) related our surgical gift to these patients on the level of Jesus' birth and his gift to the world. It was very humbling. I have included the YouTube site that explains how this Christian mission was started: <http://www.youtube.com/watch?v=pIDGySKVr9w> for those that are interested.

The caste system is still prevalent in this part of India. And heaven help you if you are deformed. Girls have it much worse than the boys. In this area, arranged marriages continues to be the norm and girls require dowries (money, land, animals) to wed. They still separate the two sexes in the church and the school. Women must wear clothing to cover below the knee and below the elbow but revealing the abdomen via the sari location of the sash is acceptable. Scrub clothes worked for me as did long skirts/dresses. Also, this helped with the bug biting population. The local area looked like an African village out of National Geographic—villages with mud floors, one room palm shacks, open markets, ox carts, etc. Our laundry was done from cistern water but dried on the available bushes within the mission area. It was colorful on laundry day.

The mosquitoes were everywhere and bit thru your clothing. I saw ants that were a minimum of two inches long, geckos everywhere, and some strange bugs I have never seen before. We lived with Deet and we had Deet atomizers in our rooms. I only was bitten twice—once on my ear and once on my foot. We all took our malaria medicine faithfully and used hand sanitizer by the bottle. The water for the mission came from a well that only was filtered 20-feet down thru sand, which was less than adequate. It was also salty as the Bay of Bengal was two miles away and the area was quite swampy with lots of rice fields and cashew trees. Rats and snakes lived in the rice fields but I did not see any, thankfully. However, most of the water came from the canals that had people urinating in it, washing clothes in it (beating clothes on the rocks) and water buffalo swimming in it. We ate no milk products as the milk was not pasteurized and TB was prevalent in it. Milk was purchased by the buyer putting his hand in the bucket and by how much cream remained on his hand (freshness test). We had rice with every meal which was very tasty. I ate a lot of "strange" food but it was all very good...lots of curry, eggs wrapped in eggplant, cinnamon curried chicken, etc.

India trip continued from page 12

Our one day off we went to the two hour church service on Sunday that included the boarded school children of the mission (girls on one side/boys on the other). Each child who is boarded must come with his/her own mattress and two sets of clothes including shoes (no flip-flops). English is taught and the kids were really cute. The school boards about 50 kids but teach about 200 up thru the 10th grade. Then later we were taken into the actual village which was about one mile away. It was obvious that we were the "pale faces." Our clothing alone stood out amongst all of the saris and the men in their toga like pants. Many people live in their shops and the open market included meat, fruit, vegetables, fish, etc. plus flies were present everywhere. Our cook who was also our chaperone/house mother led us to the different areas in the village. We found the sari store (no bigger than our office bathroom) and the material was beautiful. For \$18 you could find six yards of silk and/or cotton in all colors with all kinds of beading on it. I did buy a sari and I think I remember how to wrap it on (with four safety pins for good measure). However, in Hyderabad on the way home, we had time between flights (8 hours) to go into the bazaar and we saw outstanding silk material for saris and jeweled shoes to go with them. However, in the bazaar, we required a security guide and it was needed for our protection (beggars) and the mob of people. Everything was strictly cash transactions with 42 rupees to the dollar. However, everyone negotiated the price and it was expected by us to do so.

It was a good trip overall. We worked hard, our group got along very well with true partnership between us, and we did a lot of good work for these people. These surgeries will make a difference in these patients' future lives and well being to have these defects repaired. Plus, it was also the hope of the mission that our success will help them recruit physicians and nurses to go forward into the future and keep the hospital open. The physical plant (now that it is working) and the layout for patient flow is excellent. However, since these people could not pay, I'm doubtful that without subsidies of some kind, that will not happen. Their outside hope is for future medical team volunteers to come to help them.



Our surgical team busy at work. Thank goodness our surgeon had a battery headlight.



Our travel bags in the airport in Hyderabad, India.



Sharing the one lane road with the ox cart vender who has sugar cane roots on his cart.



The local village housing area. The water canal ran along the one lane road and supplied these homes and rice fields with daily water needs.



The local village with the open market under the tin roof.

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# Golden State Nursing Foundation (GSNF)



## Membership Form for the Golden State Nursing Foundation

Yes, I would like to become a Friend of the GSNF and receive emailed and mailed updates as to the foundations projects and events.

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Please accept this one-time donation of \_\_\_\_\_

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Please make checks payable to:

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1121 L Street Suite 409  
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Contributions to the Golden State Nursing Foundation, a tax-exempt organization under Section 501(c)(3) of the Internal Revenue Code, are deductible for computing income and estate taxes.



Save the Date

### AMERICAN NURSES ASSOCIATION\CALIFORNIA

#### GENERAL ASSEMBLY

Date: Saturday, October 29, 2011

Place: West Coast University • Ontario, California

Time (tentative): 9:30 am-4:30 pm

Agenda includes:

- Keynote: Karen Daley, President of ANA
- Continuing Education Session: Learning through Simulation
- Introduction of the ANA\C Board
- Business meeting, Bylaws and Resolutions discussion and voting
- Silent Auction and Door Prizes
- Open discussion

\*More information will be sent in the coming months. We look to forward seeing you there.

### ANA\C GENERAL ASSEMBLY October 29, 2011 (9:30 am-4:30 pm) REGISTRATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Member of ANA\C? Yes  No  ANA membership number: \_\_\_\_\_

Fee: \$25.00 Members \$35.00 non members—Includes lunch, breaks, and CE credits

I have enclosed my check payable to ANA\C in the amount of \$25.00  \$35.00  or:

Please charge to my Credit Card no. \_\_\_\_\_ Exp. \_\_\_\_/\_\_\_\_

Fax registration with credit card payment to: 916-442-4394 OR:

Mail registration and payment to:

ANA\C – General Assembly 2011  
1121 L Street, Suite 409  
Sacramento, CA 95814

\*Please check for program details and updates at: [www.anacalifornia.org](http://www.anacalifornia.org)

# Membership and Communication



## American Nurses Association \ California Membership Application



_____ Last Name/First Name/Middle Initial	_____ Credentials	_____ Date of Application
_____ Mailing Address	_____ Apt. / Unit Number	_____ Home Phone Number
_____ City / State	_____ Postal Code 'Zip'	_____ Home Fax Number
_____ Basic School of Nursing	_____ Year Graduated	_____ License Number / State
_____ Employer Name	_____ Business Phone	
_____ Title/Building/Department	_____ Business Fax	
_____ Address	_____ Postal Code	
_____ Employer City / State	_____ E-mail Address	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;">                 Referred By: _____             </div>		

**MEMBERSHIP DUES VARY BY STATE**

**Membership Category (Check one)**

- M Full Membership Dues—\$255**
- Employed—Full Time
  - Employed—Part Time
- R Reduced Membership Dues—\$127.50**
- Not Employed
  - Full Time Student
  - New graduate from basic nursing education program, within six months after graduation (first membership year only)
- Grad. Date \_\_\_\_\_
- 62 years of age or over and not earning more than Social Security allows
- S Special Membership Dues—\$63.75**
- 62 years of age or over and not employed
  - Totally Disabled

**Payment Plan (Check One)**

- Full Annual Payment
  - Check
  - Master Card or VISA Bank Card (Available for Annual payment only)

\_\_\_\_\_  
Bank Card Number and Expiration Date

\_\_\_\_\_  
Signature of Card Holder

**Payment Plan (continued)**

- Electronic Dues Payment Plan (EDPP)  
Read, sign the authorization, and enclose a check for first month's EDPP payment (contact your SNA/DNA for appropriate rate). 1/12 of your annual dues will be withdrawn from your checking account each month in addition to a monthly service fee.

**AUTHORIZATION** to provide monthly electronic payments to American Nurses Association (ANA)  
This is to authorize ANA to withdraw 1/12 of my annual dues and any additional service fees from my checking account designated by the enclosed check for the first month's payment. ANA is authorized to change the amount by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to the deduction date as designated above. ANA will charge a \$5.00 fee for any return drafts.

**Mail with payment to:**  
**American Nurses Association\California**  
**1121 L Street, Suite 409**  
**Sacramento, CA 95814**

\_\_\_\_\_  
Signature for EDPP Authorization

<b>TO BE COMPLETED BY SNA</b>			Employer Code _____	
STATE _____	DIST _____	REG _____	Approved by _____	Date _____
Expiration Date _____ / _____ Month Year			\$ _____ AMOUNT ENCLOSED	CHECK # _____
			Sponsor, if applicable _____	
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## Help us stay in touch: Do you have a new address or e-mail address?

You can help American Nurses Association\California 'stay in touch' by updating your contact information. Call ANA/C at 916-447-0225, e-mail us a [anac@anacalifornia.org](mailto:anac@anacalifornia.org) or return this form to:

The 'Nursing Voice'  
c/o ANA/C  
1121 L Street, Suite 409  
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