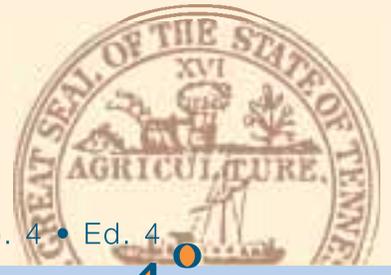


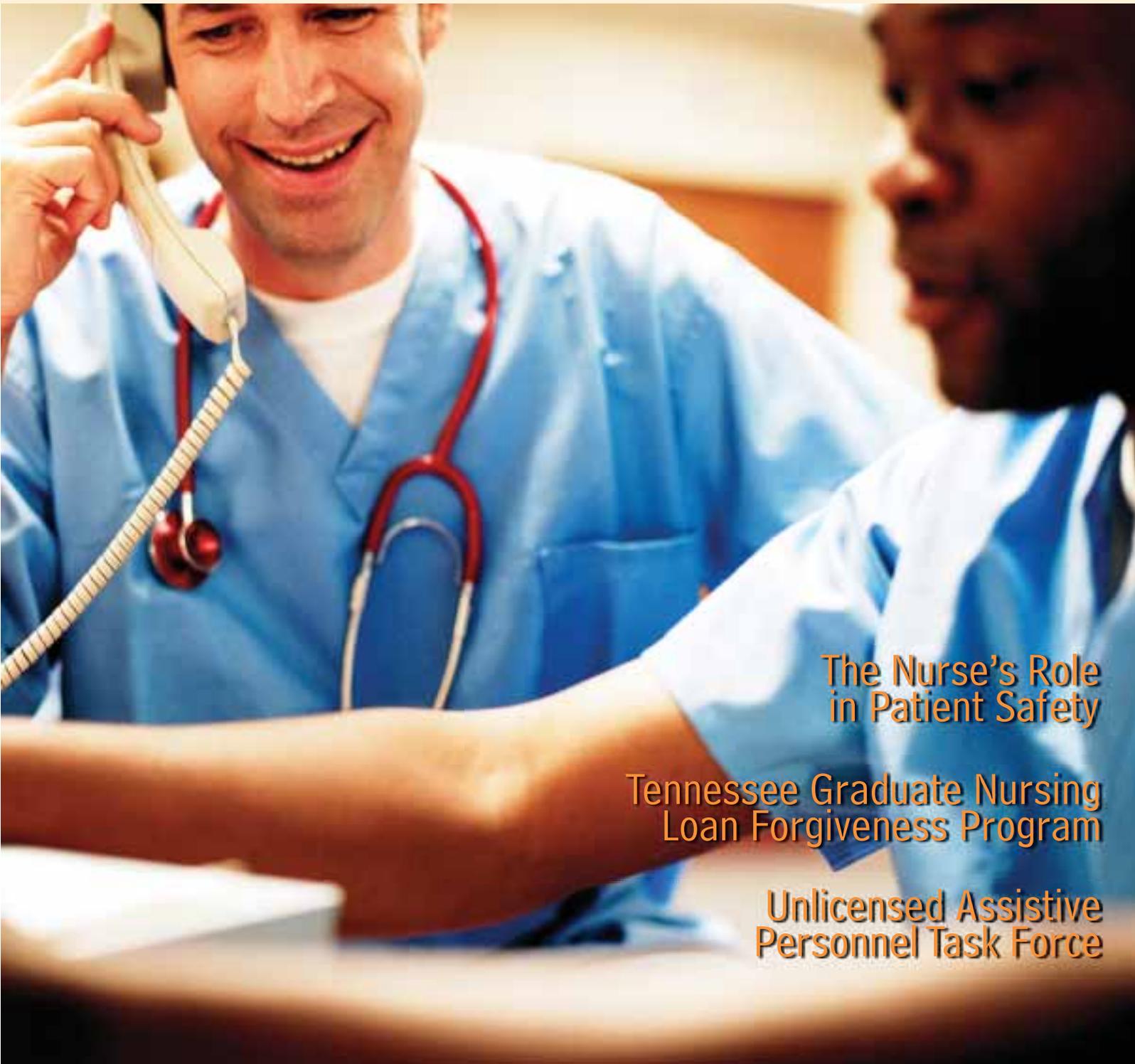
NURSING



Volume 1 • No. 4 • Ed. 4

Perspectives

A Publication of the Tennessee Board of Nursing, In Collaboration with the Tennessee Center for Nursing



The Nurse's Role
in Patient Safety

Tennessee Graduate Nursing
Loan Forgiveness Program

Unlicensed Assistive
Personnel Task Force



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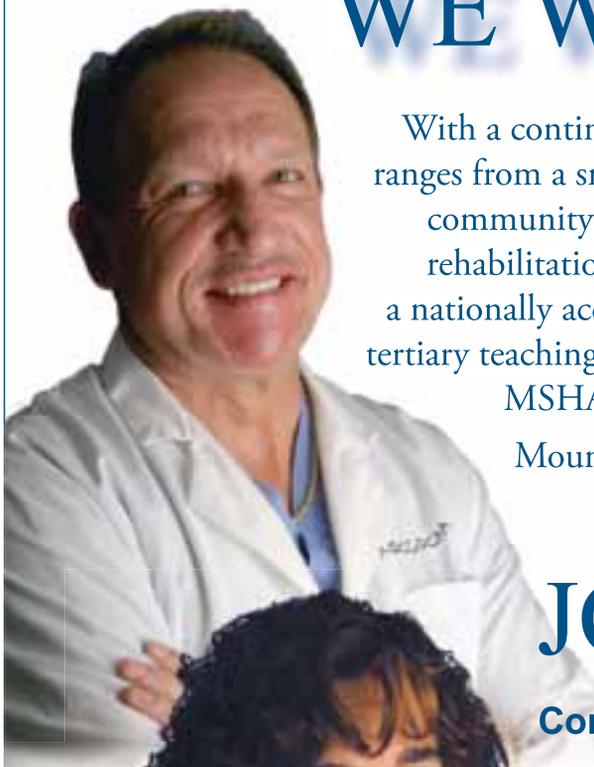
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Nursing Perspectives is published February, May, August and November by the Tennessee State Board of Nursing in collaboration with the Tennessee Center for Nursing. Each issue is distributed to every actively licensed LPN, RN, APN in Tennessee as well as to nurse employers and nurse educators. Nurses, students, and professionals from health-care organizations turn to this publication for updates on clinical practices, information on government affairs initiatives, to discover what best practices are being implemented, and for insight into how healthcare providers are facing today's challenges.

Nursing Perspectives circulation includes over 100,000 licensed nurses, student nurses, and licensed health care facilities in Tennessee.

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FROM THE DESK

OF THE EXECUTIVE DIRECTOR



Elizabeth J. Lund, MSN, RN
Executive Director
Tennessee Board of Nursing

The New Year provides the traditional opportunity for reflecting and giving thanks. First, I give thanks for the partnership with the Tennessee Center for Nursing (TCN) and Publishing Concepts, Inc. (PCI) which allows the Board to bring *Nursing Perspectives* to all licensees, supported by advertising dollars. The magazine celebrates its one-year anniversary with this issue. Thank you for the feedback that we use to improve and experiment. Let me share with you some recent suggestions and comments.

Readers reported that the magazine cover needs to be more distinctive to stand out amongst the catalogs and solicitations. Note the state seal added to the cover; it is hoped that this addition provides the gravitas that readers are requesting. Also look for board meeting dates. **All meetings are open to the public and guests are truly welcome.**

One reader brought out a point that bears discussion. She asked "To whom does *Nursing Perspectives* target as its audience?" The articles, to her, did not always apply to the practicing nurse; some appeared directed to nursing students. **It is the editorial board's goal to reach LPNs, RNs and APNs; employers of nurses, faculty in nursing programs and their students.** It's always a challenge to select articles with appeal to a broad constituency. Here is our strategy to ensure that we cover the broad gamut of topics in an orderly way: **Look for the February issue to focus on practice; May, education; August, legislation, licensure and regulation and November, research.** We will always make room for breaking news, but knowing the rhythm may help readers to anticipate a topic or narrow the search when looking for an article.

On another subject, the editorial staff wishes to get readers engaged in the magazine. Would you like to see yourself or a colleague as "Cover Nurse?" A future issue will give a Tennessee nurse star billing. **Send photos** to valda@centerfornursing.org.

Reflecting on *Nursing Perspectives* 2006, the magazine and the dialogue resulting from its publication exceeded all initial expectation. **Thank you for reading and taking the time to let us know what you think.** As always it is our intent to provide you with a magazine that speaks to your practice.

Thank you for keeping Tennesseans safe.~

Elizabeth J. Lund



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THE NURSE'S ROLE IN PATIENT SAFETY

Quality care and patient safety require a focused commitment from all levels of an organization.

Nurses are uniquely poised to have a tremendous impact on patient safety as professional caregivers in direct contact with patients and families. Nurses serve as the bedside patient safety advocate with the opportunity to **put theory into practice** each and every day as they deliver care.

The nurse's role in patient safety includes using his or her knowledge of patient safety systems and design principles in planning care; supporting a culture of safety through teamwork and collaborative practice among disciplines; identifying and reporting safety issues, including errors and near misses; educating patients and families; and participating in teams and safety activities to be part of effective solutions.

The landmark report, "To Err is Human," published by the Institute of Medicine (IOM) in 1999, focused national attention on the extent and impact of medical errors, estimating between 48,000 and 98,000 deaths were attributable to medical errors. Medical errors, in the broadest definition, include both adverse events that result in harm and any failure to render patients the recommended care at the appropriate time.

Health care, due to its complexity, the multiple processes and people involved in care delivery, is particularly prone to errors. For example, the seemingly **simple task of medication administration is estimated to include 40 to 60 steps** from ordering to the actual administration of the medication to the patient. Much of the research in patient safety for health care is based on understanding complex systems and how they contribute to errors.

Health care should continue to adopt lessons from other high risk industries, such as aviation and nuclear energy, to advance safety efforts. These industries focus on effective communication and teamwork to build a culture where safety is a top priority. Organizations with a culture of safety focus on

learning from errors and understanding why adverse events occur in a non-blaming but accountable environment.

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) sentinel event reporting and Tennessee's unusual event reporting requirements are two examples of reporting systems for adverse events. The goal of these reporting systems is to identify the underlying reasons or root causes for errors and ultimately identify effective strategies to prevent future errors. **Communication is most often cited as the reason for system failures** in evaluating the root cause of errors.

Over the past several years, numerous organizations have focused increased attention to improving the safety and reliability of health care, including the Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), National Patient Safety Foundation (NPSF) and Institute for Healthcare Improvement (IHI) (*see links to web sites at end of article for resources*).

Focused Areas of Improvement

Hospitals in Tennessee are voluntarily working with various national organizations to improve patient safety and provide information that consumers can utilize.

- **Hospital Quality Alliance:** Institutions are participating in the Centers for Medicare and Medicaid Services (CMS) public reporting quality initiatives in response to consumer demands for information about healthcare and hospital performance. Hospitals nationwide have voluntarily submitted quality-of-care information on **three common conditions that affect adult patients: heart attack, heart failure and pneumonia**. The CMS measures will be expanded over the next year to include more information on surgical care and infection prevention, as well as information on patients' perceptions and experiences with hospital care. The Hospital Compare tool at www.hospitalcompare.gov

pare.hhs.gov can be used as the beginning of a conversation with a patient's healthcare provider about the quality of care certain hospitals provide, what the hospitals are doing to improve, and what that means for his or her care.

- **Surgical Care Improvement Project (SCIP):** SCIP is a voluntary partnership of national organizations formed in 2004 to focus on surgical infection prevention and improvement in surgical care. The SCIP project's goal is to nationally reduce the incidence of surgical complications by 25 percent by the year

Nurses play a vital role in ensuring the delivery of safe, reliable care for patients.

2010. The project promotes the universal use of evidence-based care processes known to reduce surgical infections. The SCIP measures include both outcome and process measures targeting surgical site infections, adverse cardiac events, venous thromboembolism and post-operative pneumonia. The SCIP project has received the endorsement and support of key organizations, including CMS, American Hospital Association (AHA), JCAHO and American College of Surgeons.

- **Institute for Healthcare Improvement (IHI) Campaigns:** The IHI 100,000 Lives campaign, launched in January 2005, focused on patient safety through the implementation of evidence-based intervention strategies in six focus areas. The campaign included the use of "bundles," groups of care processes that, when implemented together, have been shown to reduce complications and improve

outcomes.

Over 70 Tennessee hospitals participated in the IHI campaign by implementing evidence-based strategies on at least one topic area. The success of these interventions relies on the collaboration and teamwork among physicians, nurses and other professionals at the bedside to implement care processes targeting prevention of ventilator-associated pneumonia, central line infections and early recognition, and rescue of patients at the first signs of impending decline in their condition.

This year, IHI has announced plans to launch the “5 Million Lives” campaign to reduce incidents of medical harm in U.S. hospitals over a 24-month period, ending Dec. 9, 2008. This campaign will promote the adoption of 12 interventions in care that can save lives and reduce patient injuries. It aims to enlist 4,000 hospitals, challenging all to adopt up to 12 of the interventions –

nursing work environment and patient safety and quality outcomes. Other key collaborative partners include the Tennessee Nursing Association (TNA), Tennessee Center for Nursing (TCN), Tennessee Health Care Association (THCA) and Tennessee Society for Healthcare Human Resources Administration (TSHHRA).

Recognizing the critical linkages between nursing workforce and safe and effective outcomes for patients, these provider and professional organizations are committed to working together to accelerate the adoption of evidence-based practices known to improve the nursing work environment, patient safety and quality outcomes for patients.

The collaborative project will focus on four areas:

- Building a culture of safety and teamwork.
- Providing staffing to meet individual patient needs.

among nursing leaders and nursing organizations in Tennessee. Hospital nursing leaders and nursing professional organizations have worked together on numerous projects through the THA Center for Health Workforce Development and as part of the Tennessee Center for Nursing’s efforts to address the nursing shortage.

“**Curing the Crisis in Nursing Education: A Master Plan for Tennessee,**” published in January 2005 by the Tennessee Center for Nursing, identified improving retention in the nursing workforce as one of the major goals in addition to goals and strategies to expand educational capacity. Specifically, the report recommends that employers take steps to create positive work environments based on the “forces of magnetism” from the American Nurses Credentialing Center’s magnet designation program or similar best practices for recruiting and retaining nurses in the workplace, such as the “American Organization of Nurse Executives Healthy Work Environments: Striving for Excellence, Volume I(2003) and II (2004).” The Tennessee Nursing Collaborative on Workforce and Patient Safety will incorporate the principles and recommendations from these national organizations in designing strategies for Tennessee.

Conclusion

Nurses play a vital role in ensuring the delivery of safe, reliable care for patients. Working together frontline nurses and nursing leaders can foster cultures of safety in healthcare organizations focused on improving quality and patient safety and delivering the best care possible.

Selected Patient Safety Website Resources

- **Agency for Healthcare Research and Quality (AHRQ):** <http://www.ahrq.gov/qual/>
- **Institute for Healthcare Improvement (IHI):** www.ihl.org
- **Institute for Safe Medicine Practice:** www.ismp.org
- **Joint Commission International Center for Patient Safety:** www.jcipatientsafety.org
- **National Patient Safety Foundation:** www.npsf.org
- **National Quality Forum:** www.quality-forum.org

The nurse’s role in patient safety includes using his or her knowledge of patient safety systems and design principles in planning care; supporting a culture of safety through teamwork and collaborative practice among disciplines; identifying and reporting safety issues...

six of which were included in the 100,000 Lives campaign and the following six which are new:

- New interventions targeted at harm
 - Prevent methicillin-resistant Staphylococcus Aureus (MRSA) infection.
 - Reduce harm from high-alert medications, starting with a focus on anticoagulants, sedatives, narcotics and insulin.
 - Reduce surgical complications.
 - Prevent pressure ulcers.
 - Deliver reliable, evidence-based care for congestive heart failure.
 - Get hospital boards on board.
- Tennessee Nursing Collaborative on Workforce and Patient Safety:

An exciting new partnership has been initiated by the Tennessee Organization of Nurse Executives (TONE) and Tennessee Hospital Association (THA) to focus on the

- Sharing hospital performance measures.
 - Addressing the workforce shortage.
- Examples of areas to be researched include:
- Best practices for recruitment and retention.
 - Best practices related to patient care delivery models.
 - Professional nursing skill set required to enhance a culture of safety.
 - Assertive implementation of evidence-based nursing processes known to improve care (e.g., nurse-directed IHI bundles).
 - Best practices dealing with care provider fatigue, scheduling, management of overtime, back safety programs and other safety measures.
 - Workplace design, layout and work flow.

This project builds on the strong foundation of relationships already established



The Tennessee Clinical Placement System (TCPS) *is Here*

Access to clinical placement opportunities is an essential component of nursing education, yet limited access to sufficient numbers of clinical placement opportunities remains a major barrier to enrolling the **thousands of qualified applicants who are denied admission to schools of nursing each year.** This is not only a disappointment for those seeking a career in nursing, but it threatens access to healthcare for all Tennesseans as the nursing shortage looms into the future.

Addressing this critical need, the Tennessee Center for Nursing (TCN) launched the TCPS® in fall of 2006 for schools of nursing to begin the process of placing students in their clinical rotations in spring semester, 2007. The TCPS® is a user-friendly, online clinical placement program that connects schools of nursing seeking clinical placement opportunities with healthcare facilities that offer or would like to offer clinical educational opportunities for student nurses. The program allows participating schools of nursing to view online, available clinical placement opportunities at participating healthcare facilities and **request placements in real time.** Requests are forwarded to a clinical placement coordinator who serves as a liaison between schools and

facilities to facilitate the placement request, allowing faculty and staff to concentrate more fully on their educational mission. The system also provides **online access to essential clinical orientation content** required for all students and faculty prior to the start of each clinical rotations, saving valuable time that could otherwise be spent learning on the clinical unit.

Previously, finding clinical placement opportunities for students required hours of negotiation between schools of nursing and healthcare facilities to locate and place student groups in appropriate clinical settings. Often, schools of nursing were unaware of potential placement opportunities while healthcare facilities with potential placement opportunities were unaware of or were unable to connect with the schools seeking such sites. The online system now offers rapid utilization of clinical placement opportunities along with **significant reductions in the amount of time and cost** required by faculty and staff to negotiate the student placement process.

Students, on the other hand, were required to complete onsite, face-to-face clinical orientation programs for each clinical rotation to which

continued on page 17

Ann P. Duncan, MPH, RN • Executive Director • Tennessee Center for Nursing



TENNESSEE GRADUATE NURSING LOAN FORGIVENESS PROGRAM

The Tennessee Graduate Nursing Loan-Forgiveness Program was enacted in 2006 to encourage Tennessee residents who are **nurses to become teachers and administrators in Tennessee nursing education programs.** Applicants for funding shall become a candidate in an eligible master's degree or post master's degree nursing program at an eligible institution. Awards are highly competitive and are based on funding availability.

Participants in this program incur an obligation to enter a faculty or administrative position in a nursing education program in Tennessee immediately upon completion of the education program. **For each year of continuous full-time employment** in a Tennessee nursing education program, in a teaching or administrative capacity, **twenty-five percent (25%)** of the loan will be cancelled. For each year of continuous part-time employment, twelve and one-half percent (12.5%) of the loan will be cancelled.

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To locate a graduate nursing program in Tennessee, please visit: <http://www.nursing-education-tn.org/>.

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Criminal Background “CHECKUP”

Licensure by Examination Applicants

Suzanne P. Hunt • Board Administrator, Examinations • Tennessee Board of Nursing

An important new system to assist the board to protect the public from nurses convicted of crimes occurred on June 1, 2006. Applicants for initial registered nurse (RN) or licensed practical nurse (LPN) licensure (not renewal) are now required to obtain a criminal background check (CBC) through an approved provider prior to issuance of a license. This article explains the revised process for “licensure by examination” applicants to follow to ensure a smooth and timely process.

Effective December 14, 2006 the Board agreed to make applicants eligible to test prior to the TBI criminal background check being on file. However, an applicant cannot be licensed until the Tennessee Bureau of Investigation (TBI) criminal background check has been received and reviewed by the Board.

Please note that it may take the TBI 4 to 6 weeks to release the criminal background report to the Board.

The Board suggests that applicants start the criminal background process about 6 weeks prior to graduation. All applicants **must be registered** before they can make payment or have fingerprints scanned.

To insure that applicants have registered to be fingerprinted, the board suggests that either the school of nursing registers each applicant or the applicant register him/herself by following the instructions below:

REGISTRATION

- **Telephone** – Call 1-877-862-2425 (24 hours, 7 days a week). In addition to responding to the questions listed under online registration, applicants registering by telephone will need to inform the Tennessee Application Processing Services (TAPS) representative that they have optional information which needs to be included: **Originating Case Number 1703-** for RN applicants or **1704-** for LPN applicants.
- **Online** – Applicant may register self online at www.tennessee.cogentid.com/TNRegistration.php

Applicant will be asked several questions regarding personal information, and will also be asked for the following information:

- | | |
|---------------------------------|---|
| • Agency ORI# | TN920390Z |
| • Type of Transaction | BH-VCA PL 105-251 |
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FINGERPRINTING

- Wait one day (overnight) after registration (does not have to be 24 hours)
- Bring a valid drivers license or state issued ID card
- Go to the facility nearest you to be fingerprinted, no appointment is necessary
- **Fingerprinting cannot be done until registration is completed and payment made**

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Lois Wagner, PhD, APN • Associate Director, Research • Tennessee Center for Nursing

TENNESSEE CENTER FOR NURSING: *Research in Progress*

One important goal of the Tennessee Center for Nursing is to conduct and support research focused on nursing workforce development. Below is a list of studies currently underway or in development at the Tennessee Center for Nursing. If you would like to learn more about these studies please contact our office at 615-242-8205 or visit our web site at www.centerfornursing.org.

Study Name	Description	Status
<i>New Licensee Study</i>	This study tracks newly licensed RNs over their five years of practice to describe factors associated with RN retention and workplace and educational mobility. The findings will be used to design strategies to promote retention and job satisfaction among new RNs	1-year follow-up surveys have been sent. Follow-up surveys will be sent at 2 year intervals through year 5.
<i>Schools of Nursing</i>	This is an annual survey of all LPN, initial licensure RN, Master's Degree and PhD nursing programs in Tennessee. Data tracking includes enrollment, graduation and retention rates by gender, race, and ethnicity.	All schools complete this annual survey. Data can be viewed on the TCN website.
<i>Nursing Licensure</i>	This study describes the licensure status of all LPNs, RNs, and APNs in Tennessee and describes the geographic distribution of practicing nursing by county and region of the state. Trends are followed to track the supply of nurses across the state.	Tennessee Board of Nursing licensure database is analyzed annually using 2nd quarter data. Data can be viewed on the TCN website.
<i>Failed to Renew</i>	This study will target nurses who fail to renew their nursing license to determine factors associated with failure to renew and potential strategies to promote timely license renewal.	This study is in the planning stage. Data collection will begin in spring, 2007.

Making a Decision to Recover from Drug and Alcohol Dependence

Mike Harkreader, MS, RN
Executive Director, Tennessee Professional Assistance Program



The disease of addiction affects one in four Americans either directly or indirectly from experiences with a family member or close acquaintance. The cost of this disease runs into the billions of dollars each year in direct medical costs, accidents, increased criminal activity, lost productivity and corruption. When one factors in the emotional and relationship characteristics that are involved in this debilitating disease it's obvious that financial considerations are just one of many negative consequences of addiction.

Recovery from drug and alcohol dependence is a term used to describe the process of bringing an addiction to remission. **It's essential to understand that addiction is a disease that has no cure.** Once the brain has undergone the fundamental changes in brain structure and function, the disease of addiction has been established. However, the good news is that while addiction remains, it can be successfully managed by abstinence from mood altering substances.

Recovery is a process that proceeds in various stages. One approach to understanding change is known as the **"Stages of Change" model**, which was introduced in the late 1970's by researchers James Prochaska and Carlo DiClemente who were studying ways to help people quit smoking. In their model Prochaska and DiClemente propose that change occurs gradually and relapses are an inevitable part of the process of making a life-long change. The stages in their model are precontemplation, contemplation, preparation, action and maintenance or relapse.

The first stage is **Precontemplation**. In this stage one is not considering a change. In fact, many people are, in essence, enjoying their addiction and do not see the necessity of change. **Some individuals in this stage can be described as being "in denial" and will claim that their behavior is not a problem or blown out of proportion.** Many defense mechanisms are utilized besides denial including blaming, projection, rationalization and justification. In some cases, people in this stage do not understand that their behavior is having negative consequences or are not aware of the consequences of their behavior.

If you are in this stage, begin by asking yourself some questions. Do you think you are addicted? Are other people's concerns legitimate? Have you ever tried to change this behavior in the past? How do you recognize that you have a problem? **What would have**

to happen for you to consider your behavior a problem? What might happen to you and/or your family in the future if you don't make the change?

The next stage is **Contemplation**. During this stage, people become more and more aware of the potential benefits of making a change, but the costs of doing so tend to stand out even more and **one may not accept that the substance use has to stop entirely.** This conflict creates a strong sense of ambivalence about changing. Because of this uncertainty, the contemplation stage of change can last for an extended period of time. **Individuals may attempt to "cut down" on their use.** Some never progress beyond the contemplation phase. In this stage, one may see this change as a process of sacrificing something they value, rather than as gaining any significant benefits from abstaining.

During this phase family, friends and maybe even treatment professionals can have a major influence on what decisions the addict makes in regards to change. Family members and friends can facilitate and support the addicted individual in obtaining treatment and beginning recovery, however, they likewise can make the process more difficult if they end up engaging in actions where they try and control the addict. This is how organizations like ALANON and other 12-step programs for family members can provide education and advice based on the principle of "loving detachment". **Individuals that care about the addict must accept the fact that they cannot control the addict's behaviors and choices.** They must become detached by giving up their desire for such control while remaining supportive of all sincere attempts at recovery while not assisting the addict avoid the consequences of poor choices.

If you are contemplating a behavior change, there are some important questions to ask yourself: Why do you want to change? Identify sources of ambivalence. Are these conflicting thoughts paralyzing you from making the changes you desire? **What are the consequences of not changing?**

The next stage is one of **Preparation**. During this stage, one usually begins taking small steps to prepare for a larger major life change. For example, if losing weight is your goal, then you might start by eliminating junk food, joining a health club and planning your meals with calorie reduction and nutrition in mind.

In the preparation stage, the individual who has decided to

abstain from drugs and/or alcohol starts to gather information on the necessity for treatment and what level of care will be necessary to achieve sobriety. This is a good time to talk with your doctor or an addiction professional or perhaps even visit an AA or NA 12-step meeting, which location and times can be found in the phone book, on-line or by calling your local mental health center. In a 12-step meeting you don't have to talk except for introducing yourself. The only requirement is a desire to stop drinking or using. Listen carefully to those members who have years of recovery and if you have questions perhaps you could ask them after the formal meeting ends in a one to one situation. **Being able to speak with someone who remembers what it was like to be where you are at now is helpful in that it provides hope that you can get help and resume living a productive and happy life.**

Other issues like out of pocket costs for treatment, employer notification and arrangements for the care of children or pets if one has to go to residential treatment will be necessary in this phase

The next stage is **Action**. In this phase the decision to obtain treatment has been made. An appropriate level of care is chosen depending on an evaluation of one's specific treatment needs.

may be present and treat these identified disorders simultaneously along with the addiction. **Many times these "issues" may have been covered up by the use of drugs and alcohol and will resurface once the numbing effects of the drugs no longer dull the emotional pain.**

The **Maintenance** phase (or relapse prevention) of the Stages of Change Model involves successfully avoiding former behaviors and keeping up newly acquired ones. During this stage, people become more assured that they will be able to continue their change. Try replacing old habits with more positive actions. Avoid temptation. AA addresses the phrase "people, places and things." **Avoid the people you used with, avoid the places where you used, and avoid the things associated with the use.**

If one does lapse or relapse they should not "beat themselves up". Instead, the behavior should be reframed and considered an opportunity to learn more about the disease and new relapse prevention methods. **Relapses are common** and are a part of the learning process of making a lifelong change.

When an individual goes through a relapse, they might experience feelings of failure, shame, disappointment, and frustration.

...will claim that their behavior is not a problem or blown out of proportion.



Studies have shown a correlation between length and intensity of treatment and positive outcomes, i.e., sustained recovery.

Treatment centers serve several functions and offer a comprehensive approach to treatment and recovery. **Initially some individuals require medical detoxification secondary to physical dependence on the substance of choice.** Modern detoxification protocols have made this experience much more comfortable than previously and once successful detoxification has occurred treatment centers focus on helping individuals develop the coping strategies/skills and the insightful self-awareness necessary to stay in recovery on a long-term basis after discharge from the treatment facility. The vast majority of treatment centers utilizes a 12-step approach to recovery and encourages continued 12-step involvement as part of an individualized aftercare plan. Treatment centers also work with family members in both educational and therapeutic pursuits.

In addition, modern treatment programs assess their patients for any mental health and/or unresolved family of origin issues that

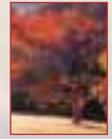
The key to long-term success is to not let these setbacks undermine their self-confidence. If one lapses back to an old behavior, they should take a long, hard look at why it happened. What triggered the relapse? What can they do to avoid these triggers in the future?

While relapses can be difficult, the best solution is to start again with the preparation, action, or maintenance stages of behavior. Recovery Coaching is a relatively new treatment approach where an Alcohol and Drug Specialist gives individualized counseling to those who have relapsed and **explores the reasons for the relapse and techniques and strategies to reduce the risk in the future.** A reaffirmation of goals, plan of action, and commitment to goals should be made. Also, plans and strategies should be made in regard to how to deal with any future temptations that will eventually be encountered.

The Stages of Change model of Prochaska and DiClemente can be utilized successfully in a variety of situations and areas where an individual wishes to make life style changes. It can also be applied to organizations as well as individuals.~



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Elizabeth J. Lund, MSN, RN • Executive Director • Tennessee Board of Nursing

UNLICENSED ASSISTIVE PERSONNEL TASK FORCE Unlicensed Assistive Personnel Task Force

The Tennessee Board of Nursing in session October 15, 2006 acted to appoint a task force **to study the issue of unlicensed assistive personnel (UAP) administering medication.** The impetus for the task force began with a board agenda item to consider culture change in long term care. This soon evolved into a plan to review the available data on medication administration by UAPs in Tennessee and elsewhere and report

...to discuss extensive data obtained through monitoring the medication aide program.

back to the board with a recommendation on the most appropriate model for **regulating unlicensed personnel who administer medications.**

Task force members include:

1. Cheryl Stegbauer, Chairman, Board of Nursing
2. Terri Bowman, Board of Nursing

3. Marian Stewart, Board of Nursing
4. Ann Duncan, Tennessee Center for Nursing
5. Judy Eads, Department of Health
6. Robbie Bell, Health Related Boards
7. Patti Scott, Tennessee Nurses Association
8. Laura Beth Brown, Tennessee Nurses Association
9. Richard Russell, Tennessee Health Care Association

In preparation for convening the first meeting of the task force the chairman and staff met with Division of Mental Retardation representatives to **discuss extensive data obtained through monitoring the medication aide program.** As many know, that program exists through an exemption or exception, written in the nurse practice act.

The National Council of State Boards of Nursing's **"Working with Others: A Position Paper"** and medication aide information from the other boards of nursing that regulate UAPs, along with the information from the Division of Mental Retardation, formed a large part of the material reviewed by the task force at the first meeting.

The task force met twice in January and continues to meet monthly.~

patient safety:

Culture Learning File No: 101.01 Justice and Accountability

Robbie Bell
Director of Health Related Boards
Tennessee Department of Health



PURPOSE:

To set out the Health Related Board’s philosophy concerning learning, justice and accountability.

POLICY:

A. Given that:

1. Medical errors and patient safety are a national concern to all involved in health care delivery.
2. The Health Related Boards are legally and ethically obligated to hold practitioners accountable for their competency and behaviors that impact patient/client/resident care.
3. A punitive environment does not fully take into effect sys-

3. Distinguish between human error, at-risk behavior, and intentional reckless behavior.
4. Foster a learning environment that encourages the identification and review of all error, near-misses, adverse events, and system weaknesses.
5. Support the prevention of future errors by promoting the use of a wide range of responses to safety-related events including coaching, non-disciplinary counseling, additional education or training, demonstration of competency, additional supervision and oversight and disciplinary action when appropriate to address performance issue.
6. Work to share information across organization to promote



We resolve that the Health Related Boards will Distinguish between human error, at-risk behavior, and intentional reckless behavior.

continuous improvement and ensure the highest level of patient/client/resident/staff safety.

- (a) Collaborate in efforts to establish a statewide culture of learning, justice and accountability to provide the safest possible environment of patients/clients/residents.
7. In reviewing complaints filed with the Boards, the consultants and staff will consider the following blameworthy activity that may result in board action:
 - (a) An event or medical error that is a result of a practitioner’s actions while under the influence of alcohol or drugs.
 - (b) The practitioner responsible for the error has blatantly disregarded the facility’s policies and procedures or professional standards of practice.
 - (c) The practitioner is being purposefully or recklessly unsafe.
 - (d) The practitioner commits an intentional and/or criminal act (including abuse, neglect or misappropriation of patient/resident property).~

tems issues, and a blame-free environment does not hold practitioners appropriately accountable.

B. We resolve that the Health Related Boards will:

1. Strive for a culture that balances the need for a non-punitive learning environment with the equally important need to hold persons accountable for their actions.
2. Judge based on behavior, not the outcome.

they were assigned, despite the fact that the majority of orientation content is redundant from site to site (HIPPA, OHS, Fire Safety, etc.). As students are assigned to as many as four clinical rotations per semester, they lost days of valuable clinical time on the unit to these orientation programs. With the online system, students can access required clinical orientation content at any time from any computer and **complete their orientation requirements in just under two hours.** In addition, students are now required to complete this orientation content **only once a year** as opposed to prior to each clinical rotation. Once they view the content and successfully complete the online quiz, they can download and print a certificate of completion that is accepted by schools and facilities as proof of having met this requirement.

The Ultimate Goal: "Building Capacity for Healthcare Education"

Tennessee is projected to have a nursing shortage of 35,300 RNs by the year 2020. If the shortage is not averted, our state will be able to meet only 53% of the demand for nurses by 2020. This will negatively impact Tennessee's future access to affordable, high-quality health-care.

Though schools of nursing have increased enrollment by 52% over the past four years, in 2005 approximately 2,383 qualified applicants were denied admission to nursing programs in Tennessee due to nursing faculty shortages, lack of clinical practices sites, and other resources constraints. The TCPS© is just one of several strategies being implemented by the TCN to increase educational capacity in nursing and avert the nursing shortage in Tennessee. In response to increasing demand, the TCN has begun the process of expanding access to the TCPS© in other regions of the state. Over the next year the program will become available in the **Memphis, Chattanooga, and Upper East Tennessee** areas and plans are underway to expand access to three additional regions in 2008. If you want to learn about the TCPS© or are interested in joining the partnership, go to the TCN website at www.centerfornursing.org and click on "The Tennessee Clinical Placement System". If you have additional questions please call the TCN at 615-242-8205.~

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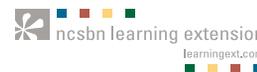
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E-LEARNING FOR THE NURSING COMMUNITY

Tennessee Leadership Institute for Nursing Excellence (T-LINE)

The Tennessee Leadership Institute for Nursing Excellence (T-LINE) was initiated in 2004 as a collaborative venture between the Tennessee Center for Nursing (TCN) and the University of Tennessee College of Nursing. Based on several successful national programs, the Leadership Institute has two primary goals:

- 1) Recognition and advancement of clinical leadership of among young professionals, and
- 2) Retention of nurses in the workforce.

Didactic and interactive learning experiences are incorporated in the 3½ day program held annually at Fall Creek Falls State Park. Developed by two College of Nursing faculty, Dava Shoffner, PhD, RN, and Maureen A Nalle, PhD, RN, **the curriculum generally focuses on such leadership issues as Professional Advocacy, Ethics, Team Building, and The Magnet Journey.** A major purpose of the Institute is to support leadership growth in clinical Registered Nurse staff through experi-

ences introducing many of the competencies and skills necessary to become effective leaders both in the workplace and in the community. A second purpose is to demonstrate to staff nurses that their role as a direct care provider is **valued by both their employing agency and their professional colleagues.**

Each year, twenty nurses from across the state are invited to participate from every area of practice ranging from acute care to public health. Nurses are selected based on defined criteria related to demonstrated clinical leadership skills, supervisor/administrator recommendations, the nurse's own perspective of her career goals, and potential for professional leadership. Eligibility criteria include:

- AD or BSN preparation;
- Primary role in direct patient care;
- Within first five years of their professional nursing career.

Funding and support for T-LINE is shared between nurse employers and the Tennessee Center for Nursing. Employers

provide paid time for their employee (no loss of salary for the RN), as well as travel reimbursement. All other expenses (tuition, lodging, and meals) are provided through a generous grant from TCN.

This year, The T-LINE is scheduled for **May 14-17, 2007 at Fall Creek Falls State Park.** Application information was sent from the Tennessee Hospital Association to nurse administrators in February with a deadline of March 14, 2007. For more information please contact Dr. Shoffner at dshoffne@utk.edu. Details will be published at www.centerfornursing.org in the near future.~



Dava H. Shoffner, PhD, RN
Associate Professor
University of TN - Knoxville



Maureen A. Nalle, PhD, RN
Assistant Professor
University of TN - Knoxville

T E N N E S S E E B O A R D O F N U R S I N G

Meeting Dates

Unless otherwise noted, all events take place at 227 French Landing, MetroCenter, Nashville, Iris Board Room, 8:30 am Central

2007

Business	Feb 22 Sept 27
Hearings	March 7-8 May 30-31 Sept 5-6 Dec 5-6

2008

Hearings	March 3-4 June 4-5 Sept 3-4 Dec 3-4
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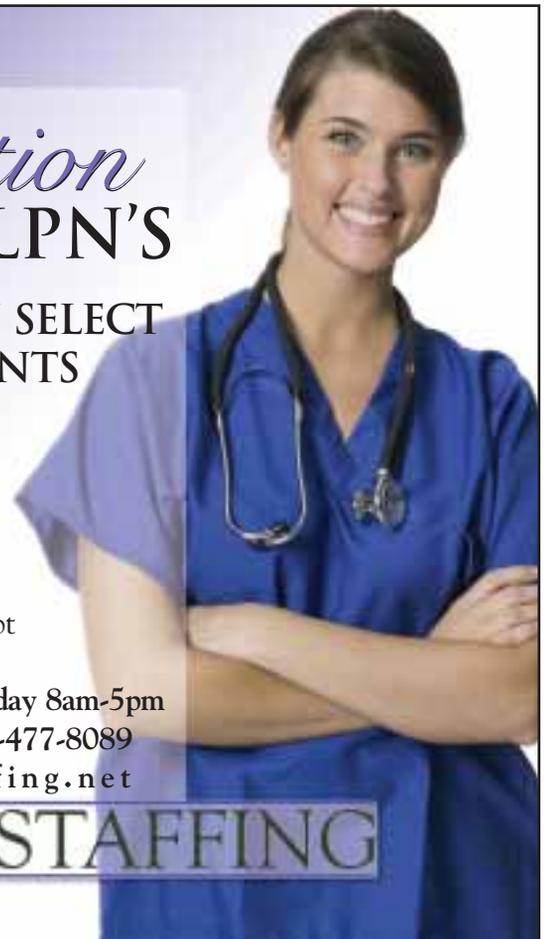
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R E S P O N S E S T O . . .

Frequently Asked Questions

NURSE LICENSURE COMPACT

1. *I hold a Tennessee nursing license. Why does it not state “multistate”? By the way I live in Alabama.*

A nurse who resides in a non compact state is only eligible for a Tennessee single state license. Multistate licenses are only issued to residents of compact states.

2. *I am a Tennessee employer of nurses. The prospective employee resides in Tennessee, but holds a single state Tennessee license. The nursing web site shows discipline on the license (probation). Why is the license single state, not multistate?*

Licenses under current disciplinary action are prohibited from holding a multistate license; therefore, the licensee is issued a single state license and may only practice in Tennessee.

3. *I have voluntarily signed a confidential contract for monitoring with the Tennessee Professional Assistance Program (TNPAP). The contract I signed states that I may only practice in Tennessee. My licensure status on the Internet indicates I hold a multistate license. As I continue to hold a multistate license, may I practice in Arkansas on this license?*

No. Your contract with TNPAP is a privilege authorized by the Board of Nursing to support rehabilitation of impaired nurses. Nurses under contract are offered confidentiality from Board of Nursing so long as the nurse maintains compliance with the contract.

4. *What states belong to the Nurse Licensure Compact?*

Go to www.ncsbn for a current list and map of participating states.

5. *How do I prove residency in Tennessee?*

To prove residency in Tennessee when moving from another compact state you must complete a declaration of primary state of residence. Proof of residency is required. Acceptable documentation includes a Tennessee driver's license, voter registration, or federal income tax return (W-2 withholding form).

6. *I hold LPN licenses in FL, AL, GA and TX. Do I need a TN LPN license when I work in a facility located in Tennessee?*

It depends. If your primary state of residence is Texas (or any other compact state) and you hold a multistate license you may practice in Tennessee on the multistate privilege. However, if you move to Tennessee and Tennessee becomes your primary state of residence you must apply for a Tennessee license and provide proof of residency. You must maintain a license to practice in the respective non compact state (FL, GA, AL) if you choose to practice there.

7. *I am in the military stationed in Tennessee. My permanent state of residence is Texas. May I practice in Tennessee on my Texas multistate license?*

Yes.

8. *I am in the military stationed in Tennessee. My permanent state of residence is Georgia. I hold a current Georgia RN license. Do I need to apply for an RN license in Tennessee? Am I eligible for a Tennessee multistate license?*

continues on page 22

FACULTY INSTITUTE FOR EXCELLENCE IN NURSING EDUCATION

The First Annual Faculty Institute for Excellence in Nursing Education sponsored by the Tennessee Center for Nursing was held at Vanderbilt University School of Nursing, May 31- June 2, 2006. We had 32 nursing faculty representing 19 schools. A major purpose of the Institute was to support leadership growth and educational excellence in nursing faculty. Experiences introduced many of the competencies and skills necessary to become effective educational leaders in schools of nursing.

On the first night of the Institute, **Carla Sanderson**, DSN, RN, Provost of Union University, provided an inspiring talk about the developing role of nursing faculty. The content of the sessions were focused on: **teaching strategies that facilitate learning for nursing students accounting for generational differences, educational technology that enhances teaching strategies to improve the learning environment, understanding the challenges and opportunities for inter-professional learning in health professions education, and clinical teaching strategies that promote clinical competency development and assessment.** The focus for the 2007 Institute is on preparing new nursing faculty for the challenges of nursing education. The conference will be held at Vanderbilt University School of Nursing **April 17-19, 2007** using the Holiday Inn on West End for hotel services. The Deans and Directors of RN Nursing Programs have the information concerning the workshop.~



Faculty Institute attendees participate in a BaFa BaFa simulation experience to understand what it is like to interact with a different culture. It was preparatory for the discussion on intergenerational differences.

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With The Med's affiliation with the University of Tennessee Health Science Center you will have the opportunity to work with some of the best doctors and nurses in a teaching and research environment.

The hospital is the clinical site of the UTHSC Department of Neurosurgery Division of Neurotrauma, which has been designated one of eight sites in the U.S. to participate in the Traumatic Brain Injury Clinical Trials network funded by NIH. The UTHSC division/department and hospital are also members of the American Brain Injury Consortium, which focuses on clinical research related to traumatic brain injury.

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For purposes of practicing in a military/federal facility, a Tennessee license is not required. For nursing practice outside of a military/federal facility, you must obtain a Tennessee single state license. A Tennessee multistate license is only given for Tennessee residents.

9. *I changed my address on the web site to North Carolina. I have not received my Tennessee renewal. When my employer checked the Tennessee web site my licensure status had been changed to multistate void. My license expiration date is not until next month. Please send my renewal.*

You are not eligible to renew in Tennessee as you are now a resident of another compact state. You may only hold one license among compact states--in your state of residence. Once Tennessee received information that your address changed to another compact state, Tennessee "voided" your Tennessee multistate license. If you are only in North Carolina on a temporary assignment and Tennessee remains your primary (legal) state of residence, please contact the board office.

10. *An employee of a Tennessee hospital lives temporarily in Mississippi with a permanent address in Florida, practices in Tennessee and holds a Tennessee single state license. Should the nurse apply for a RN license in Mississippi and practice in Tennessee on the nurse licensure compact privilege?*

The nurse in question holds permanent residence in a non compact state, Florida. This residence is documented by income tax filing status. The nurse temporarily resides in Mississippi and holds a single state Tennessee RN license. As you know, a nurse who does not reside in Tennessee is not eligible for a Tennessee multistate license, but is granted a single state license. Even though the nurse holds a Mississippi driver's license, the permanent address is Florida and the proper license to practice in Tennessee in this case is the Tennessee single state license.~

T E N N E S S E E B O A R D O F N U R S I N G

POSITION STATEMENT • March 1999 • Reaffirmed December 2001 • Revised December 2002

ABANDONMENT OF PATIENTS

Madeline C. Coleman, RN, JD, CPHQ • Nursing Consultant • Tennessee Board of Nursing

Inquiries have been made to the Tennessee Board of Nursing (TBON) regarding which actions by a nurse constitute patient abandonment. According to the Rules and Regulations of the Tennessee Board of Nursing patient abandonment is unprofessional conduct and thus may lead to discipline against a nurse's license.

Patient abandonment is a term which is often used by health care regulatory agencies, employers of health care personnel, the nursing profession and the consumer. The Board believes that the term "patient abandonment" must be defined, and differentiated from "employment abandonment."

For patient abandonment to occur, the nurse must:

- Have first **accepted** the patient assignment, thus establishing a nurse-patient relationship, and then
- Severed** that nurse-patient relationship without giving reasonable notice to the

appropriate person (e.g., supervisor, patient) so that arrangements can be made for continuation of nursing care by others.

A nurse-patient relationship begins when responsibility for nursing care of a patient is accepted by the nurse.

Recruiting and maintaining appropriated licensed staff is the responsibility of the facility. If at the close of a shift, the facility does not have the appropriately licensed staff to ensure the continuity of nursing care, then the employer shall make all reasonable attempts to obtain such staff. **Failure of a nurse to work beyond her/his scheduled work shift will not constitute patient abandonment as defined by the Board.** Also refusal to accept an assignment or a nurse-patient relationship and failure to notify the employing agency that the nurse will not appear to work an assigned shift is not considered patient abandonment by the

Tennessee Board of Nursing.

Failure of a licensed nurse to comply with a facility policy involving mandatory overtime, refusal to accept an assignment or a nurse patient relationship and failure to notify the employing agency the nurse will not appear to work is an employer-employee issue.

The Board believes that failure of the licensed nurse to provide the employer with sufficient notice of intent to end the employment relationship does not constitute patient abandonment. However, the Board does encourage licensees to end their employment relationships in a professional manner.

The licensed nurse who follows the above policy statement will not be considered to have abandoned the patient for the purposes of board disciplinary action. Again, it should be noted that the board has no jurisdiction over employment and contract issues.

Adapted from the California Board of Registered Nurses and Connecticut Board of Nursing.~

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