Massachusetts Board of Registration in Nursing
Board News…

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The mission of the Board of Registration in Nursing is to *lead* in the protection of the *health, safety and welfare* of the citizens of the Commonwealth through the fair and consistent application of the statutes & regulations governing nursing practice & nursing education

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What's New…

The Board hosts Dr. Lucian Leape. At their annual Board retreat on November 8, 2006, the Board welcomed patient-safety expert Dr. Lucian Leape and Ms. Paula Griswold, Executive Director for the Massachusetts Coalition for the Prevention of Medical Errors. They discussed the latest innovations in patient safety and various best practice recommendations for the continued safe and effective delivery of nursing care to the citizens of Massachusetts. The discussion was engaging, enlightening and thought provoking for all in attendance.

Massachusetts nurses participate in NCLEX ® Item Development. The following nurses recently represented Massachusetts in the National Council of State Boards of Nursing (NCSBN) National Council Licensure Examination (NCLEX ®) item development program: Catherine M Hill, Sharon Pease, Janet Lusk, Gaylourd Anthony Tagupa Ayag, Michelle Colleran Cook, Karen Anne Carpenter, Kathleen Williams Kafel, Kimberley Ann Brown, and Shauna DAlleva. Thank you all for the important contribution you have made to the future of nursing.

The Board receives comments regarding 244 CMR 4.00: Massachusetts Regulations Governing the Practice of Nursing in the Expanded Role Task Force Recommendations. During their regularly scheduled meeting on December 13, 2006, the Board reviewed comments received in response to the Task Force recommendations. Comments were received from 10 of 49 organizations/stakeholders, as well as from members of the APRN community. The Board agreed by consensus that entry-into APRN practice includes at minimum, a graduate education containing the core courses of advanced assessment, pathophysiology, and advanced pharmacotherapeutics. Additionally, the Board agreed that entry-into practice also requires the applicant to hold national certification, and for those who will be affected by these changes that grandfathering language be developed. The Board also reached consensus that the scope of advanced registered nurse practice be regulated at a domain (i.e. NP/NA/NM/CNS) level versus at a specialty level; practice be across the life span based on the individual's competency to care for a population; that the non-psychiatric CNS be regulated as an APRN; and to engage in formal discussions with the Board of Registration in Medicine regarding physician supervision and practice/prescriptive guidelines. Finally by consensus, the Board concluded that further investigation is needed and authorized a subcommittee of the Board to study outstanding issues. The subcommittee will include representatives from the practice domain organizations and Board members and staff.

Faculty Resources now online. Following the highly successful Educate-the-Educator seminar held in Shrewsbury on October 6, 2006, for faculty of Board-approved nursing education programs, Board staff developed an "educator toolbox" available on its website. The tool box consists of various Board documents including the *Regulation of Nursing Practice* model curriculum and

other faculty resources. The goal is to provide faculty and Board-approved nursing education programs with the resources necessary to teach students about the legal basis for practice and through stronger partnerships with the individual schools, to enhance students' understanding of the laws and regulations governing nursing. The tool box can be viewed at www.mass.gov/dph/boards/rn >Nursing Education>Faculty Resources>Regulation of Nursing Practice: A Model Curriculum.

Valerie Iyawe joins the Board Staff. On Monday November 13, 2006, Board staff welcomed Valerie Iyawe who joined the staff as a Substance Abuse Rehabilitation Program (SARP) Coordinator. Valerie comes to the Board with multiple years of psychiatric mental health nursing and leadership experiences, most recently with the Adult Intermediate Care Unit at the Erich Linderman Mental Health Center in Boston. Valerie has an associate's degree in nursing from Massachusetts Bay Community College, a BSN from Framingham State College, and an MBA from Nichols College. Welcome Valerie!

From the Board Chair

Diane Hanley, MS, RN - Chairperson

Communication. There's a word we hear a lot about today. In fact, communication is identified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goals (NPSG) for 2006 which will be surveyed for implementation in 2007. Goal Two of the NPSG states, "*Improve the effectiveness of communication among caregivers*." Implementation of this goal is articulated by some of the changes you may have been seeing in your workplace. For example, new processes for the reporting of critical test results, updated and approved lists of acceptable abbreviations, and new formats for standardizing "hand-off" communications.

Hand-off communication is defined by Solet, Norvell, Rutan, and Frankel (2005) as, "*Any transfer of role and accountability from one person to another*." They found in their study of the literature on patient hand-offs that there exists a variability in the systems of handing-off information. Additionally, they found a broad number of barriers to effective handoffs, such as the physical and social setting, language and communication barriers, and time and convenience. Based on this study the authors recommend development of standard educational practices and incorporating hand-off tools into existing information technology systems.

Likewise, Sutcliffe, Lewton, and Rosenthal (2004) identified in their analysis of 70 incidences that communication and patient management factors contributed the most to the incident. This qualitative study analyzed interview findings from resident physicians at a single teaching hospital and demonstrated that communication failures are common in daily practice, and the barriers to effective communication are both individual and systemic.

In 2004, Leonard, Graham and Bonacum found that:

- Communication failures account for the overwhelming majority of unanticipated adverse events in patients;
- Medical care is extremely complex, and this complexity coupled with inherent human performance limitations, even in skilled, experienced, highly motivated individuals, ensures there will be mistakes;
- Effective teamwork and communication can help prevent these inevitable mistakes from becoming consequential, and harming patients and providers;

- Embedding standardized tools and behaviors, appropriate assertion, and critical language can greatly enhance safety;
- Communication tools can effectively bridge the difference in communication styles, experiences, and among and between the various members of the healthcare team.

What is the current state of communication among and between all of the providers you interact with each day? My guess is that it fluctuates, and at best it is consistently inconsistent. Why is it then, that something as basic as communication, and as important as patient hand-off remains one of those activities that we are not always good at doing? I haven't been able to answer the question fully myself, but I am hopeful when I hear that there are new models being developed, new formats being created, and a renewed sense of the importance at conducting a meaningful hand-off between nurses is spreading among our colleagues.

Let's all commit to doing our part in correcting what appears to be a simple problem to fix; talking to each other. What is easier than that! If your workplace doesn't have a hand-off tool yet, try these tips when giving or receiving report:

- Organize the information in a logical format such as head-to-toe, problem-oriented, or by the SBAR (situation-background-assessment-recommendation) technique being tested in many places;
- Keep the information concise and accurate, repeating information that is on a flow sheet or kardex is not always necessary; be discriminating in what you report;
- Include a summary of the patient's current condition or status, giving only pertinent facts, symptoms, etc;
- Refer to an established problem list or care plan that truly captures the patient's needs;
- Provide a description of each measurable outcome of the care that was given and how that outcome was achieved;
- Remind people of the things yet to be accomplished and as appropriate review:
    - Resuscitation status
    - Recent lab values
    - Allergies, diet and activity level
    - Medication histories

New hand-off tools and models are difficult to get everyone to agree to and use, but don't get discouraged by those who are slower at embracing change. Remind them nearly 90% of every error occurring in healthcare involves communication. Together we can steadily decreased errors by focusing on communication that is precise and worthy of a best practice strategy.

From the Board Executive Director

Rula Harb, MSN, RN - Executive Director

We learned to document in school. Many of us learned documentation principles based on a particular style or format such as Subject-Objective-Assessment-Plan (SOAP), Data-Action-Response (DAR), or Problem-Intervention-Evaluation (PIE). For me it was the narrative, a style that has never really gone out of

fashion. What is most interesting about any format is that it's designed to capture the same information about a patient; assessment, plan, intervention and evaluation. How could something as easy as that, be so easy to spoil? More important, how do we correct it?

We correct it by returning to the basics. First, leave no doubt in the record that the patient was continually assessed, monitored, evaluated and cared for by a competent nurse. Second, document only the facts that you have gathered with clear, objective and correctly used terminology. Next, chart events in the sequence in which they occurred including notification of any other healthcare team member by name, and not combined into one entry at the end of the shift. Remember to date and time your entry, use complete sentences, correct spelling and grammar and above all, be legible. And last, be sure that all your documentation is signed with the name and licensure level as it appears on your license.

Your documentation should:

- Tell the whole story
- Not contain gaps
- Accurately record the patient's assessment and response to care
- Reflect timely notification of any other healthcare provider of patient problems and the response including any new orders received
- Demonstrate how the prescriber orders were implemented
- Contribute to decreasing medical errors
- Convey patient teaching
- Be evidence that safe, effective, quality and competent nursing care was delivered successfully
- Be reflective of facility policies & procedures

From the Nursing Education Coordinator

Judith Pelletier, MSN, RN - Nursing Education Coordinator

FACULTY VACANCIES AMONG BOARD-APPROVED NURSING EDUCATION PROGRAMS IN MASSACHUSETTS 2005-2006 through 2007-2008

Spring 2006 Survey

The Massachusetts Board of Registration in Nursing (Board) surveyed nursing education program administrators in early March 2006 to collect and analyze data to describe nursing faculty vacancies among the 62 Board-approved nursing education programs for academic years 2005-2006 through 2006-2007. Findings from the 2004 faculty vacancy study conducted by the Board identified salary range as well as competition with the practice setting as contributing to faculty vacancies among Massachusetts basic nursing education programs.

A total of 49 nurse administrators responded to the survey: 17 of 21 (81%) Practical Nurse (PN) programs and 32 of 40 (80%) Registered Nurse (RN) programs.

PN programs project a slight decline in student enrollment through academic year 2007-2008; however, the actual enrollment in PN programs for academic

year 2005-2006 was greater than projected in 2004.

RN programs project growth in student enrollment through academic year 2007-2008. The actual enrollment in hospital-based diploma and associate degree programs for 2005-2006 was less than was projected in 2004 and in baccalaureate and higher degree programs actual enrollment was higher than had been projected in 2004.

Return to clinical practice was rated as the factor most frequently cited as contributing to pending RN and PN faculty vacancies. This was closely followed by moving to another position in academia and retirement. Among both RN and PN programs, program expansion or change was also cited as a significant factor.

All program types rated salary range as having the greatest overall impact on the program's ability to recruit qualified faculty.

Among all RN and PN program respondents, pediatric nursing followed by obstetrical nursing ranked as the most difficult clinical specialties for which to recruit qualified faculty. Medical-surgical nursing ranked third among RN and PN programs. Networking and "word-of-mouth" were cited by the majority of RN and PN program respondents as the most successful methods for recruiting qualified faculty.

The availability of a competitive salary and benefit package to offer applicants was cited by RN and PN program respondents as the preferred strategy to address faculty vacancies and to assure the preparation of graduates for safe, competent, entry-level practice.

Most RN program respondents reported appointing at least one clinical or skills laboratory instructor with an individual for whom the Board had granted a 244 CMR 6.04(2)(b) 3 waiver of the requirement for an MSN. Had the waiver policy not been available, one-half of RN survey respondents identified a reduction in student admissions would have potentially occurred. The Board granted 198 244 CMR 6.04(2)(b)3 Waivers in fiscal year 2006, an increase of 44% over fiscal year 2005.

Consistent with the 2004 study, a non-competitive salary for nurses seeking employment in academia persists as a theme in the responses from survey participants. The impact of salary is not only on recruitment, but on retention of qualified faculty as well; respondents reported they are losing nursing faculty to other nursing education programs and to clinical practice.

The vacancy rates reported in the Board's 2004 and 2006 surveys demonstrate an existing shortage of qualified nursing program faculty in Massachusetts which is expected to worsen over the next several years. For 2003-2004 the actual vacancy rate for PN programs was 7%, it rose to 9% in 2005-2006, but is projected to decline minimally to 5% for 2007-2008. Likewise in the total RN programs, the 2003-2004 rate of 5% grew slightly to 6% during 2005-2006, and is projected to be 11% in the 2007-2008 timeframe.

The Board's Spring 2006 Nursing Faculty Vacancy study makes available data that may be used by nursing program faculty and healthcare providers

statewide, as well as legislators, regulators, and post secondary and higher education administrators in the planning for the Commonwealth's current and future nursing education program needs.

From the Nursing Practice Coordinator

R. Gino Chisari, MSN, RN - Nursing Practice Coordinator

Some estimates put the rate of turnover for newly licensed nurses between 35 - 60 percent within the first year of employment of the newly licensed nurse (Halfer & Graf, 2006). Turnover is estimated to be approximately 40,000 dollars per nurse in hiring and orientation costs, while the emotional cost to the new nurse and staff is immeasurable. In Kramer's classic work, Reality Shock: Why Nurses Leave Nursing, first published in 1974, she described reality shock as occurring during the transitional period of student to nurse where there are different priorities and pressures. Kramer described this period as the first 18 months of practice.

Although this isn't a new phenomenon, what is new is the growing realization that unless something successful is developed, nursing practice as we know it will change forever because the rate of demand will eventually over take the rate of supply. If forced, the system will have no other alternative but to look outside of nursing for solutions. The bottom line is that facilities will still be required to care for sick people.

We should be asking ourselves, how we can help. The profession uses the number 2.6 million to identify the number of nurses in the country while in Massachusetts we are about 123,000 nurses strong. These are great numbers, but we all know that the demand for qualified nurses is growing rapidly and it is time for collaborative action.

The literature tells us that the newly licensed nurses' concerns center around having mixed emotions between being excited at being licensed and the "fear" of being responsible for the outcomes of the patient's plan of nursing care; being influenced and effected by their preceptor's values, feelings and reactions; trying to overcome the knowledge gaps between what was "taught" in school and "how its done" in the workplace; and the frustration of mediating a complex schedule of rotating days and shifts, relationships with other members of the healthcare team, and assimilating the professional role.

Each of us who has successfully made this transition possesses the experience, skills and advice to provide role-modeled behavior for our newest members. Providing support isn't always easy but maybe by remembering to do these simple things we can make the transition easier and in doing so find that being a part of the solution is easier than we first thought.

The next time you find a newly licensed nurse on your team try these strategies:

- Extend a warm welcome and offer to be of assistance. A new nurse needs to know that there is someone they can go to who won't judge, but who will listen and share knowledge;
- Make yourself available with an offer to "help-out" when you see the new nurse struggling to get through their assignment or trying to deal with a difficult patient, or colleague. New nurses are not skilled at multi-tasking through a multiple patient assignment;
- Offer praise when the new nurse performs well, we all respond and are

encouraged by being recognized for a job well done;

- Offer support and understanding when the new nurse makes a mistake, it won't be the first, but the first will remain with the new nurse through out their career, help them turn it into a positive learning experience;
- Be fair; just because the nurse is new doesn't mean that she (or he) has to work all the unattractive days and shifts; and

Remember; remember back to your own transition period. I bet there was a very kind and supportive experienced nurse who was always there for you. Be that nurse and be remembered fondly as a caring supportive professional who did the "little" extras for new nurses.

From the Licensure Coordinator

Michael Bearse - Administrative Supervisor

Welcome to 2007! Starting on January 1 and running through December 31 of 2007 it is an LPN license renewal cycle. As a reminder to all nurses renewal applications are mailed 8 weeks before your birthday to your address of record. This is why it is most important for the Board to have your current address. If you fail to notify the Board, your renewal application may not be forwarded on to you by the post office. Once you have completed your renewal application and have mailed it back with the correct fee amount made payable to the Commonwealth of Massachusetts, the process, which takes about two weeks to complete, includes:

- Deposit of the check and clearance by the bank;
- Update of the license expiration date on the database and website;
- Printing of the hard-copy, wallet-sized paper license;
- Quality assurance inspection of the printed batch which can take up to 10 days;
- Mailing to the address of record.

Knowing that it takes some time to complete the renewal process, all nurses are encouraged to renew their license as soon as they receive their application. Remember, you must have a current license in order to work. So, don't delay, renew early!

From NCSBN

The National Council of State Boards of Nursing's (NCSBN) Practice, Regulation and Education Committee members will host an exciting forum on transitioning new nurse graduates to practice. The keynote speaker will set the stage with a broad vision about the importance of transitioning new practitioners in health care fields. Other speakers will provide a national and international view of transitioning new nurses to practice. A panel discussion of stakeholders will address transition from their unique perspectives, and the day will culminate with the participants engaging in a rich dialogue and providing valuable insights for designing transition models.

Transition of New Nurses From Education to Practice: A Regulatory Perspective
Thursday, February 22, 2007
University of Chicago's Gleacher Center
450 North Cityfront Plaza Drive, Chicago

Objectives:

1. Discuss the vision of transitioning new nurse graduates from a broad health care perspective.
2. Examine the national and international perspectives of transitioning new nurses to practice.
3. Seek input from stakeholders and participants about models for effectively transitioning of new nurses

For more information please visit www.ncsbn.org

Question of the Month

Q: I was told that since my nursing unit now has an automated medication supply machine (i.e. Pyxis ®) that I no longer need a second nurse to witness any waste of a narcotic, is that true?

A: No, that is not true. The Board reminds all nurses that when wasting a medication in Schedules II - V, the nurse must have a second nurse witness the waste and then document it accordingly. The Board also reminds all nurses who document that they have witnessed a wasted medication to be sure that you actually see the medication getting wasted. It is inappropriate, bad practice and a violation of the regulations to document your name to a medication waste that you did not actually see. Likewise, it is inappropriate, bad practice and a violation of the regulations to ask a fellow nurse to document witnessing your waste, when they did not observe you wasting it.

Important Information

- All nurses licensed by the Board are reminded of the Board's regulation at 244 CMR 9.03 (8): Identification Badge. It state, " *A nurse who holds a valid license and who examines, observes, or treats a patient in any practice setting shall wear an identification badge which visibly discloses at a minimum his or her first name, licensure status and, if applicable, advanced practice authorization*."
- Errata: In the Board's October 2006 newsletter it incorrectly stated that the disciplinary action list available on the Board's website was from 2005. It should have read from January 1, 2006. The Board apologizes for any inconvenience that may have caused.
- Next edition will be available March 2007, please stay tuned!