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Evidence-Based Practice: Why Does It Matter?

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The author and planning committee members have declared no conflict of interest.

This independent study has been designed to empower nurses to engage in evidence-based practice to strengthen their own professional roles. **1.6 contact hours** will be awarded for successful completion of this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

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OBJECTIVES

1. Define evidence-based practice.
2. Describe ways to use evidence-based practice to ensure safe patient care.

Introduction

Evidence-based practice has become a commonly used term in health care in the past few years. It is important for nurses to know what it means, how to use it, and how important it is in protecting patient safety. This study will define evidence-based practice and provide examples of how evidence based practice questions can be used to guide delivery of safe patient care. The purpose of the study is to empower nurses to engage in evidence-based practice to strengthen their own professional roles.

Significance

In 2002, Sigma Theta Tau International, the honor society of nursing, developed a position statement on evidence-based practice. This paper describes how important it is for nurses to be able to access, evaluate, integrate, and use "best practices" to promote patient safety. The document was revised in 2005 and is available at http://www.nursingsociety.org/aboutus/PositionPapers/Pages/EBN_positionpaper.aspx. (STTI, 2005). In this document, the society defines evidence-based practice as "integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families, and communities who are served."

The National Council of State Boards of Nursing (NCSBN) has stated that evidence based practice is not just another buzz-word or fad, but that it is an expected standard of ensuring safe patient care that is "here to stay" (Spector, 2007).

Regulatory boards in each state exist for the purpose of protecting the public. One way to do that is to be sure that nurses are practicing in a safe and competent manner. For example, the Ohio Board of Nursing has rules in the Ohio Administrative Code (OAC) that relate to competent practice for registered and licensed practical nurses (4723-4-03 OAC and 4723-4-04 OAC, respectively). One aspect of competence is that "a registered nurse shall maintain current knowledge of the duties, responsibilities, and accountabilities for safe nursing practice." (4723-4-03(B) OAC). Similar language exists in rule 4723-4-04 OAC for the licensed practical nurse. The term *current* means that the nurse is expected to keep abreast of new knowledge, research, and evidence that supports nursing interventions, keeps patients safe, and contributes to quality patient care.

The purpose of the Ohio Board of Nursing, and boards of nursing in all other states as well, is to protect the public. Implementation of evidence-based practice is one strategy for the nurse to use to make sure that the public is protected when nursing care is provided.

Over the past several years, the Institute of Medicine (IOM) has published a series of reports related to patient safety in the United States health care system. Their 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, states that the attributes of quality care are safety, effectiveness and efficiency, patient-centeredness, timeliness, and equity. Evidence-based practice provides the foundation for safe care, leading to increased effectiveness and efficiency, timeliness, and more appropriate focus of research-based data within the framework of the patient's current situation and needs. This in turn leads to equity in utilization of resources and assurance that each patient receives the most appropriate individualized care, according to his/her presenting needs.

In 2004, the IOM published a seminal work focused on improving the work environment for nurses as a significant strategy to keep patients safe. Key components of improving the work environment for nurses are stimulating nurses to seek evidence to support practice, providing the resources and tools nurses need to collect and evaluate that evidence, challenging them to assess the evidence in relation to a specific patient's need, and empowering them to take the initiative to implement best practices.

It is clearly understood that nurses do not work in a vacuum; they must work effectively as members of the healthcare team. The Joint Commission has emphasized the need for all healthcare providers to work together more effectively in the best interests of quality patient care. Their Sentinel Event Alert issued in July of 2008, for example, states that "safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment." Use of evidence based practice tools provides a common framework for discussion, shared involvement, and decision making. The SBAR example for interprofessional communication included later in this study is one example of an evidence-based practice that has contributed to more effective team interaction.

The 2010 IOM report, Redesigning Continuing Education in the Health Professions, supports the requirements of The Joint Commission in advocating for ongoing learning across professions that supports integration of evidence based practice to improve patient outcomes. This report recommends, among other things, that "continuing education efforts should bring health professionals from various disciplines together" (p. 3) in learning environments that focus on evidence based practice and practice based evidence to close gaps in practice that impact patient care.

In 2011, the IOM published an extremely important report, The Future of Nursing: Leading Change; Advancing Health. This report has been the stimulus for development of action coalitions in states around the US to implement the recommendations for nursing to be more visible, more active, and more committed to making a difference in the US healthcare system. There are a number of recommendations in this report that focus on nurses practicing to the full scope of their knowledge and skills, nurses as leaders in the transformation of the healthcare system, and nurses achieving higher levels of education that provide them with the ability to critically analyze data and make effective decisions to provide quality care for patients.

In an era where cost effectiveness and efficiency in healthcare operations are key, it is also important to consider the economic benefit of using evidence based practice. Schifalacqua, Soukup, Kelley, and Mason (2012) describe a cost-of-care metric used to calculate cost savings that accrue when healthcare-acquired conditions are prevented through use of evidence based practice standards. In their example, one healthcare system was able to document cost-avoidance (money that didn't have to be spent to care for patients with these conditions) of $8 million in one year! This is clear evidence that evidence-based practice makes a difference – both in terms of preventing avoidable clinical complications and in terms of saving money for the organization.

Definition

Evidence-based practice, in its simplest form, means using evidence to guide practice. This is an alternative to

Evidence-Based Practice continued on page 4

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Inside This Issue

Evidence-Based Practice: Why Does It Matter? 1-6
CE4Nurses.org 2
National Priorities Partnership 7-11
The Board's Disciplinary Authority: What Does It Mean & How Does It Happen? 12-15

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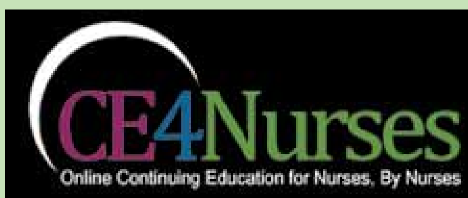

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Non-members can also complete the studies published in this issue online for $12 per study or by mailing in the tests provided for $15 per study. See page 3 for more details.

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References

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Questions

Contact Sandy Swearingen (614-448-1030, sswearingen@ohnurses.org), or Zandra Ohri, MA, MS, RN, Director, Continuing Education (614-448-1027, zohri@ohnurses.org).

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Evidence-Based Practice continued from page 1

"flying by the seat of your pants," doing things "because we've always done them that way," or doing things "because I don't know what else to do, so I'll try this and see how it works." Nurses enter practice with a knowledge base that has been acquired through formal education, including opportunities for both didactic learning and clinical practice. This education forms the basis for beginning practice and serves as a springboard for future professional development. This is NOT the end of the learning process!

New evidence comes into play every day as research is completed, technology advances, and patients present with unique challenges and personal experiences. The nurse who bases practice solely on what was learned in basic nursing education soon becomes outdated, then becomes dangerous. Patients are not safe if they do not receive care that is based on the best evidence available to assist them at the time their needs arise.

Titler (2008, p. 1-113) defines evidence-based practice as "the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions." Evidence comes from several sources, including research, our past experiences, the knowledge and experience of colleagues, and the patient/family. One of these alone does not constitute a solid frame of reference for determining a plan of care.

Similarly, Sigma Theta Tau International (2005), in its position paper, defines evidence-based nursing as "an integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families and communities who are served." This takes into account not only the research-based evidence, but the unique situations nurses face when implementing best practices with people of various cultures, needs, and health care preferences. Sigma Theta Tau considers evidence based nursing as a foundation for nursing practice.

Melnyk and Fineout-Overholt (2005) also address the fact that evidence based practice is predicated on several factors: evidence from research, opinion leaders, and expert panels; evidence from assessment of the patient and related healthcare resources; clinical expertise, and information about the patient's preferences and values. Taken together, this framework empowers the nurse to plan and implement evidence-based clinical decision making.

Using Research

When available, research studies that have been conducted in controlled circumstances provide strong evidence to support practice decisions. For example, research has been done to determine various types of wound care dressings that are most appropriate for different kinds of wounds.

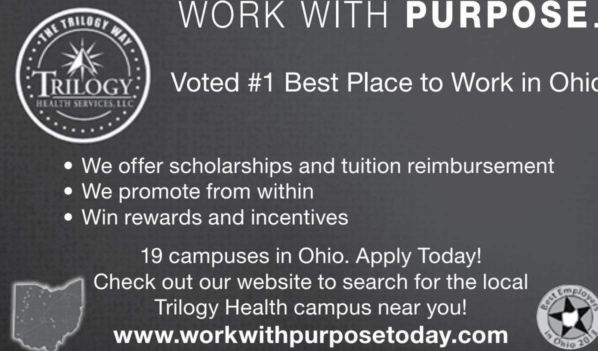
The nurse caring for a patient with a decubitus ulcer needs to thoroughly assess the patient and the wound, and then review the research to determine the best option to aid wound healing. As the nurse and the physician review the patient's situation, they can develop a plan that incorporates recommendations based on research findings, the specific characteristics of the wound, and the patient's situation – lifestyle, current self-care capability, availability of resources, and other factors that will determine how the treatment plan is carried out.

There are many areas of nursing practice, however, in which structured qualitative and/or quantitative research has not yet been done. There may be anecdotal evidence from others' experiences, or there may be some "soft" data generated by one or two research studies with small populations or with a different focus than the area of current concern. New research is being conducted in a variety of areas of nursing practice and is disseminated through resources such as the National Institute of Nursing Research (NINR) at the National Institutes of Health, the Agency for Healthcare Research and Quality (AHRQ), and Sigma Theta Tau International.

The following information is provided in the "frequently asked questions" of the NINR, found at http://www.ninr.nih.gov/Footer/NINR+FAQ.htm.

Q: What is Nursing Research?
A: Nursing research develops knowledge to:

- Build the scientific foundation for clinical practice,
- Prevent disease and disability,
- Manage and eliminate symptoms caused by illness,
- Enhance end-of-life and palliative care.



Many nurses cringe at the topic of "research." They are unsure of how to read research articles and how to discern the "take home" points from lengthy descriptions of statistical data collection and analysis. Several sources, including the University of Southern California (Guide to Reading Research Articles, 2010), have published tools to aid in reviewing this literature. Key questions they suggest include:

- What is the purpose of the research and how does it relate to the problem?
- How was the investigation done? Was the study conducted in accordance with sound principles and without bias?
- What are the findings and conclusions, and how do they relate to the problem?
- How are the findings applicable to my practice?

Other factors the reader might want to consider when reviewing published research data include:

- How big was the data base in the study? A study that only looked at responses of 10 patients to a nursing intervention may not yield data that is as beneficial as a study in which 100,000 patients were assessed. After all, if six out of ten patients responded positively to a nursing intervention, the response rate would be 60%. That number looks impressive. It isn't nearly as impressive, however, if six out of 100,000 patients had the same response - then it would only be .006%!
- What was the population in the study? If the study looked at the effects of an antidepressant medication on adults and your patients are children, the results of the study will not benefit your current practice.
- Who funded the study? Publishers and authors disclose the sources of funding for their research. If a study comparing the effectiveness of two antihypertensives was conducted by a pharmaceutical company that makes one of the medications, what steps were taken during the design, implementation, and analysis of the study to ensure that the study was factual? Please note that it is not unethical or illegal for a pharmaceutical company to fund research about its medications. In fact, this is a critical tool for evaluating the effectiveness of a medication. What is critical is to ensure that (1) bias is prevented in the conduct of the study, and (2) readers of the study have full disclosure about funding.
- Who conducted the study? What were the qualifications of the people who carried out the work? Did they have a particular "vested interest" in the outcome? Unfortunately, there have been situations where researchers have had a particular desire to see a certain outcome of a study, so data are manipulated in such a way to make the desired outcome a reality. To protect integrity and try to prevent misuse of subjects and data related to them, facilities in which research is conducted have institutional review boards (IRBs). Prospective researchers submit their proposals to IRBs to get approval prior to conducting their research if human subjects are involved. There may be situations where a researcher is receiving funding from a product manufacturer, or the researcher serves on the speakers' bureau for the company that makes the product – in these cases, the researcher has to be sure that his/her involvement with the company does not introduce bias into the research process. Some organizations allow this researcher to continue with the research as long as disclosure is provided and integrity is maintained; other organizations disallow the researcher from participating in that particular research project. Publishers are required to disclose any potential "conflicts of interest" of authors and to indicate how these potential conflicts were resolved.
- What were the outcomes of the study? Do they make sense in relation to the original research question that was asked? Do they have any relevance to your practice or your population of patients? If so, you will want to look further into the statistical analysis of the data to see how the researchers arrived at their conclusions. If not, consider the review of this study as an adventure in new learning, and move on to something else!

While research is an important component of evidence-based practice, an important factor to remember is that one research study does not generally provide "evidence." A nurse can search databases for individual articles. These include CINAHL, MEDLINE, and others. More valuable is a compendium of research studies that have resulted in publication of evidence that comes from several sources. Three notable sources of this type of data are the Cochrane Collaboration, the National Guideline Clearinghouse, and the Agency for Healthcare Research and Quality. All three of these sources provide searchable databases that enable the user to collect evidence compiled from a number of sources in relation to a specific clinical problem.

In some cases, such as the National Guideline Clearinghouse, the evidence has been used to formulate a guideline that is then considered to be a "standard" of practice, based on best-available evidence at the time the standard was written. That is another significant factor to consider – when was the study done, and how current are the findings? Review of the literature may point to evidence of change in a standard over time – the prudent nurse will be aware of the most recent sources of evidence.

Spector (2007) states in the NCSBN paper that it is important for nurses to recognize the difference between "research utilization" and "evidence-based practice." While research utilization suggests that one adopt the findings of a research study as "standard practice," evidence-based practice indicates that findings from multiple studies, in conjunction with thorough assessment of the current patient situation, form the basis for nursing plans and interventions. She states that goals of this process are to give nurses tools to provide excellent care, provide a valid and reliable way to solve clinical problems, and encourage innovation and creativity in how evidence-based data is implemented to meet specific patient needs. As additional clinical problems and challenges are identified, there is opportunity for more innovation as new strategies are implemented to address ongoing quality improvement initiatives.

Tools and Resources

Policies and procedures of facilities should be based on evidence, not on tradition. One recommendation is to include a footnote with each policy, stipulating the foundational documents that were used in formulating the policy. Regularly scheduled policy reviews can then be conducted by referring to the original sources of data to look for updates and changes.

One example of an evidence-based practice standard that has been shown to increase patient safety is the SBAR tool for interprofessional communication (IHI, 2010). Numerous studies over the past several years have indicated that a major cause of patient safety lapses in acute care settings has been poor communication among members of the healthcare team. As noted earlier, The Joint Commission issued a sentinel event alert in July of 2008, indicating that hospitals must take a more active approach in ensuring respectful, appropriate communication that fosters a culture of teamwork and trust. The SBAR communication tool has proven to be an effective resource to assist healthcare team members in addressing that concern.

The model uses the acronym SBAR to stand for situation, background, assessment, and recommendations. When one member of the team is giving report to another or calling a colleague for guidance, use of this framework provides a consistently reliable way of collecting, analyzing, and organizing data to share with the other person. It is a particularly valuable tool for new members of the team, as they are learning strategies for effective communication. The process is more intuitive for more proficient practitioners. Regardless of whether use of the standard is formal or informal, it provides a way to share data that is understood by both parties, includes relevant information, and excludes extraneous information that might "muddy the water" in making sure the patient's needs are appropriately addressed. Evidence has shown that integration of this technique in shift-to-shift reports, transfer of a patient from one department to another, or call to a prescriber regarding a change in plan of care has resulted in clearer communication and better patient outcomes.

Several models have been developed to assist people in using evidence to guide their practice. One is the ACE Star Model of Knowledge Transformation©, developed at the University of Texas Health Science Center at San Antonio (Stevens, 2004). According to this model, the five points of a star represent key points in development of evidence-based practice: discovery, evidence summary, translation, integration, and evaluation. New data is discovered, but only as evidence from several studies supporting that finding are accumulated can the data be summarized into a framework that then can be translated into expectations for practice. At that point, nurses need to be educated and system-wide adjustments have to be made in order for those expectations to be incorporated into practice. For example, evidence could show that providing report at the patient's bedside is an effective tool to promote patient safety and enhance staff functional ability, but if staff is not educated about how to do this new process effectively, it will not be utilized appropriately. Similarly, if staff are educated, but policies and procedures are in place that dictate how report is to be given in the conference room with certain people present at each change of shift, the new practice still will not be able to be implemented. At times, changes in policy/procedure, technology, and/or the culture of the unit or organization are needed in order for new evidence to be incorporated into practice.

Many healthcare organizations have implemented quality improvement or process improvement initiatives, such as the PDCA (plan/do/check/act) process and Six Sigma. These are examples of use of evidence-based practice, starting from the premise that organizations need to work toward quality, cost-effectiveness, and efficiency. While the initial onset of quality improvement initiatives has taken place in the manufacturing and industrial sectors of the economy, hospitals and other healthcare organizations have embraced their value. In light of the IOM reports referenced earlier in this study that indicate hospitals have issues that affect safety for patients and preclude effectiveness and efficiency of providers of care, healthcare organizations are now realizing the need to be more accountable in both the services they provide and

Evidence-Based Practice continued on page 5

Evidence-Based Practice continued from page 4

the infrastructure that supports provision of those services. According to the American Society for Quality (2009), hospitals have reported success rates in both clinical and non-clinical services as a result of using quality improvement processes.

Another model is one suggested by The University of Minnesota (2010). In this model, there are five key processes one uses to collect, use, and evaluate evidence based data. First, the nurse must frame the correct question in order to search databases for appropriate supportive literature. Second, from the literature resources available, find those which are most appropriate to your particular situation, patient need, or clinical challenge. Next, review those articles using some of the questions and suggestions in the "Using Research" section above. After finding supportive evidence of the initiative to be implemented, develop and use the evidence. The final step in the process is then to re-evaluate - did the process work as intended? Did the generalized evidence support the particular need in this case? Is this something that could be used by this facility in similar situations in the future?

Megel (2009) suggests a framework similar to the University of Minnesota model to develop processes staff nurses can use to frame research questions, collect and analyze relevant data, and implement the findings to improve quality of care. She suggests that formulation of the question is a key to the process of data mining. Since there is so much data available, strategically framing the question to be asked significantly reduces the amount of material that is retrieved by the search engine and aids in focusing on the most helpful information. A well-designed question is thought to include the following:

P: the patient or population
I: the intervention that is being considered
C: comparison interventions, if available (is "A" better than "B"?)
O: desired outcome

For example, a question might be posed as "for a normal-weight newborn, is breast-feeding or bottle-feeding more effective in protecting the immune system?" The population under consideration is the normal-weight newborn, so you can immediately rule out any articles that discuss breast feeding benefits for premature babies. The intervention being considered is breast feeding, and the desire is to compare the relative benefits of breast feeding and bottle feeding to achieve the desired outcome of protecting the newborn's immune system. Data from the evidence retrieved will guide the nurse in education of new mothers. Nursing interventions are thus based on evidence, rather than on "usual" practice at the hospital or the personal preference of the nurse who happens to be caring for the patient that day.

Stillwell, Fineout-Overholt, Melnyk, and Williamson (2010), provide helpful information in their article, *Searching for the Evidence*. They suggest, too, use of the PICO formula, with addition of a "T," to address the time required to achieve the outcome (PICOT). This article also presents a "hierarchy of evidence" to help the nurse evaluate the relative quality of various sources of evidence.

The National Database of Nursing Quality Indicators® was established in the late 1990's as a vehicle for collecting data about nurse-sensitive indicators - those variables that reflect the structures, processes, and outcomes that affect the quality of nursing care that is provided to patients in hospitals. The database has grown significantly in its ten-year history and has contributed substantially to the evidence supporting nursing's critical role in patient safety. Data are collected from member hospitals and benchmarked with other facilities and quality standards. Reports are provided to the members, which can be used for internal quality improvement initiatives, reporting requirements, staff education, and recruitment/retention efforts. Evidence of quality nursing practice is substantiated through controlled data bases such as that maintained by NDNQI®.

Professional nursing associations also have a wide variety of activities currently underway to investigate and support evidence-based practice in particular areas of nursing. Just as two examples, the Oncology Nursing Society has substantial evidence-based practice information available in regard to nursing care of patients with cancer. The Emergency Nurses Association has practice standards, publications, and guidelines based on best practices in emergency nursing. Contact a professional association of interest to you to learn about the resources, education, and data bases they currently have available.

Other Sources of Evidence

Clinical Expertise

With all of this discussion surrounding research and data bases, don't lose sight of the fact that collecting evidence from the literature is only one step in implementing evidence-based practice. Going back to the definition of evidence-based practice, remember that there are three key components: the evidence, clinical expertise, and the patient. Clinical expertise is a required element of evidence based practice. That might be the expertise you have, or the "borrowed" expertise of a colleague or mentor. Recognizing when you need help, and finding the appropriate person to provide that assistance, enables you to "data mine" to develop a strong evidence-based plan of care.

Clinical expertise comes with clinical experience. The novice nurse is very focused on policy and procedure and "how to do," rather than "what to do" or "why to do," let alone "how and when to modify" based on a patient's need at any given point in time. As clinical experience grows, the nurse transitions to higher levels of thinking and functioning (Benner, 1984). As the nurse progresses from novice through the stages of advanced beginner, competent practitioner, proficient provider, and expert, the ability to think about "what if" strategies increases significantly. The nurse who is able to do "what if" thinking explores options and alternatives and uses research-based evidence to support recommendations to modify a plan of care to meet unique needs of an individual patient.

Critical thinking, while taught in nursing schools, is more of a theoretical exercise until there is a practice framework to guide the thinking. The more experience the student has, the better the critical thinking ability will be. Critical thinking derives from the ability to look at the big picture, ask relevant questions, seek additional information, and challenge the "usual." It includes the nurse's ability to not only collect data, but to analyze that data in context with the patient situation. Critical thinking requires that the nurse be present in the moment and not act reflexively in providing what may be perceived as "routine" care. According to Benner and colleagues (2008, p. 1-88), "critical thinking involves the application of knowledge and experience to identify patient problems and to direct clinical judgments and actions that result in positive patient outcomes."

You may have a significant amount of clinical expertise, based on years of practice and continued learning. It is a misjudgment, however, to assume that expertise and length of practice are equivalencies. Many nurses have practiced for a significant number of years but have not continued their professional development, either formally or informally. This often leads to ineffective, inefficient, and ultimately dangerous practice, as this nurse is not able to keep up with new advances in knowledge and technology.

Because of the increased specialization of nursing, no one nurse can be expected to be knowledgeable about every aspect of the profession. Therefore, it is most helpful to have trusted resources that can be called upon to provide expert guidance. For example, a patient with chronic depression is admitted to a medical-surgical unit after having a stroke. The med-surg nurse might feel quite capable of handling the post-CVA needs of her patient but is not sure of the right approach in dealing with the co-morbidity of chronic depression. A phone call to the psychiatric unit can elicit the support of a mental health nurse to provide guidance and direction in addressing the unique needs of this patient.

Expertise can be gained in a number of ways. Certainly, years of experience helps. Continuing education, both formal advanced academic education and continuing professional development, helps to keep the nurse updated and aware of new developments in his/her area of practice. Attending activities such as the hospital's "grand rounds" or other in-service opportunities helps the nurse continue to learn and grow. Membership in a professional association expands the nurse's horizons in a particular practice area of interest.

The Patient

As important as critical thinking is, by itself, it is not enough. Critical thinking forms the foundation for applying clinical judgment (sometimes called clinical reasoning) to a specific situation. Clinical reasoning is defined (Benner, 2008, p. 1-90) as occurring "within social relationships or situations involving patient, family, community, and a team of health care providers." In other words, clinical judgment takes the ability to critically think and applies it to a particular patient with a particular need at a particular point in time. All of the evidence in the world is not going to matter if it is not relevant in this specific instance.

True understanding of the patient includes many facets and is based on the nurse's knowledge of biological and social sciences in general and an assessment of the patient/family situation in particular. Knowledge of the patient's spiritual frame of reference, cultural background, decision-making processes, and health-related values is just as important in planning appropriate care as knowing the person's HgA1C or triglyceride levels.

Another factor to keep in mind is that the patient's condition is not static. A nursing assessment is only valid for the moment of time in which it was conducted. The nurse must be continually vigilant to changing conditions, which call into play new "evidence" that must be considered in adjusting the plan of care. Additionally, the nurse must always be thinking forward - anticipating what is probably going to happen next, while at the same time being prepared to respond if things don't go as planned. Nurses have often been called a hospital's "first-responders" because they are typically the ones who first recognize that a hospitalized patient is in need of emergent assistance based on a changing condition. In fact, the rise of rapid-response teams in healthcare facilities has been brought about by evidence suggesting that the nurse at the bedside is in the best position to recognize a patient's need and call for the appropriate resources to aid in care of the patient.

Summary

Evidence based practice is a reality, and a critical component, of today's healthcare practice. The nurse must be aware of and able to use evidence based practice in order to promote patient safety. Effective utilization of evidence based practice depends on the ability to find and analyze data, critically examine a patient's current condition and needs, and apply the appropriate interventions to achieve the desired outcome. Patient safety and quality of care are at stake. Evidence based practice provides an efficient, effective, and cost-beneficial way to provide care.

Evidence-Based Practice continued on page 6

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Evidence-Based Practice: Why Does It Matter?

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:_______________________________________

Date:____________________ **Final Score:** __________

Please circle one answer.

1. Learning from prelicensure education is adequate to enable the nurse to practice safely throughout his/her career.
   a. False
   b. True

2. Evidence to guide practice decisions can come from:
   a. Experience
   b. Patients
   c. Research
   d. All of the above

3. In the PICO formula, the "O" is indicative of the:
   a. Objective
   b. Operation
   c. Opportunity
   d. Outcome

4. In the PICO formula, the "P" stands for:
   a. Possibilities for actions
   b. Prediction of the desired outcome
   c. Problem the patient has
   d. Procedure the nurse is considering

5. In the PICO formula, the "I" stands for:
   a. Individual needs of the patient
   b. Intervention being considered
   c. Investigation technique to be used
   d. Involvement of the healthcare team

6. In the PICO formula, "C" is used to indicate:
   a. Coordination of the plan
   b. Communication strategies
   c. Comparative interventions
   d. Comprehensive plans

7. The group that represents all of the state boards of nursing is the:
   a. NCSBN
   b. NNSDO
   c. NNCOC
   d. NRB

8. The Ohio Board of Nursing has a rule regarding practice according to ____ knowledge, skills, and ability.
   a. Acquired
   b. Current
   c. Previously learned
   d. Tested

9. The National Council of State Boards of Nursing states that evidence based practice is a
   a. Buzz word
   b. Fad
   c. Fallacy
   d. Reality

10. A nurse who practices only based on what was learned in nursing school becomes:
    a. Dangerous
    b. Inefficient
    c. More proficient
    d. Stronger

11. The purpose of the Ohio Board of Nursing is to:
    a. Perform public service
    b. Protect the public
    c. Provide post-graduate nursing education
    d. Safeguard the nurse

12. Policies and procedures are best written based on:
    a. Accreditation requirements
    b. Evidence
    c. Experience
    d. Tradition

13. One research study is usually not adequate to provide evidence for clinical decision-making.
    a. False
    b. True

14. Sigma Theta Tau International considers evidence based practice to play what role in nursing practice?
    a. Experiential
    b. Foundational
    c. Guiding
    d. Supportive

15. SBAR is an evidence-based practice standard used for:
    a. Communication among health professionals
    b. Maintaining adherence to Joint Commission standards
    c. Reporting patient safety violations
    d. Working through patient clinical problems

16. The National Institute of Nursing Research is part of the:
    a. American Nurses Association
    b. National Honor Society of Nursing
    c. National Institutes of Health
    d. World Health Organization

17. Pharmaceutical companies cannot conduct research about medications they make.
    a. False
    b. True

18. An important aspect of reading a research article is to look at:
    a. How bias was prevented in the design, implementation, and analysis of the study
    b. How many people researched and/or authored the study
    c. How the results of the study have been used by other organizations
    d. Why the investigators chose to study this particular issue

19. A process to validate the integrity of a research study is use of an:
    a. Administrative Research Review
    b. External Panel of Experts
    c. Institutional Review Board
    d. Optimal Research Outcomes Analysis

20. Evidence-based practice suggests that findings of several research studies support the planned intervention.
    a. False
    b. True

21. Education of nurses about change in practice based on new evidence is sufficient to create new practice.
    a. False
    b. True

22. For new evidence to be integrated into practice, there needs to be:
    a. Education, system-wide support, and availability of resources to make the change
    b. Enough staff to implement the new plan
    c. Data from at least five sources to support the need for a change in current practice
    d. Wide-spread understanding that the new process will not cost more than the current one

23. The National Database of Nursing Quality Indicators® is a data collection venue for nursing indicators of quality in:
    a. All healthcare settings
    b. Ambulatory Care
    c. Hospitals
    d. Nursing Homes

24. The SBAR acronym stands for:
    a. Sample size, Biology, Anatomy, and Research
    b. Situation, Background, Assessment, and Recommendations
    c. Suggestions, Basis of opinion, Algorithms, and Responses
    d. Surgery, Bariatrics, Anesthesia, and Radiology

25. Evidence to support evidence based practice comes from:
    a. Empirical research, previous experience, and clinical data
    b. Evidence-based study, analytical data, and NDNQI
    c. Supportive data, use of EBP models, and non-biased research
    d. The literature, clinical expertise, and the patient

26. Sigma Theta Tau defines evidence based practice to include:
    a. Evidence based on the nurse's personal value system
    b. Information that was learned in nursing education programs
    c. Standards of practice from licensure boards
    d. Values and preferences of individuals and families

Evaluation

1. Were you able to achieve the following objectives? **YES** **NO**
   a. Define evidence-based practice. ___Yes ___ No
   b. Describe ways to use evidence-based practice to ensure safe patient care. ___Yes ___ No

2. Was this independent study an effective method of learning? ___Yes ___ No

   If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form? _____________

4. What other topics would you like to see addressed in an independent study?

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National Priorities Partnership

Developed by:
Barbara Brunt, MA, MN, RN-BC, NE-BC

The author and planning committee members have declared no conflict of interest.

This independent study has been developed to provide nurses with an overview regarding the National Priorities Partnerships and the National Priorities and Goals which aim to focus performance improvements in healthcare. **0.96 contact hour will be awarded.**

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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OBJECTIVES

1. Define the National Priorities Partnership and the National Priorities and Goals.
2. Identify strategies to achieve goals of eliminating harm, eradicate disparities, reduce disease burden, and remove waste.

STUDY

It is a commonly held belief that the American healthcare system is broken. We are experiencing an economic and healthcare crisis. The number of uninsured is very high and growing. The health of our population is declining and disparities in care still persist. Unless America rethinks and revamps its healthcare system, our global eminence and domestic social and economic well-being will continue to slip away (National Priorities Partnership, n.d.).

Consider the following facts:

1. The United States spends more per capita on healthcare than any other industrialized country. Yet our results on many important indicators of quality, such as preventable deaths and timely access to primary care, fall significantly below those of similar nations. (Squires, 2012)
2. In 2012, U.S. health care spending was $7,960 per person. (Squires, 2012). Without major changes in the way the US pays for and delivers health care, total national health spending is projected to rise to $4.6 trillion – or nearly 20% of the GDP- by 2020. (The Commonwealth Fund, 2012)
3. The percentage of persons under age 65 years with private coverage was 67% in 2007. Since 1990, the percentage of nonelderly persons without coverage has remained stable, but the number has increased by more than 6 million persons, to 43.3 million in 2007. (Cohen, et al., 2009)
4. Racial and ethnic minorities, and those in low income groups, face disproportionately higher rates of disease, disability, and mortality (Institute of Medicine, 2002). Even though some strides have been made since 2002, there are still significant disparities in the United States (Cohen, 2008).

One of the organizations that have been working on these challenges is the National Quality Forum (NQF). NQF is a unique, multi-stakeholder organization that has been instrumental in advancing efforts to improve quality through performance measurement and public reporting. NQF is a private, not-for-profit membership organization with more than 375 members representing virtually every section of the healthcare system. Its mission to improve the quality of American healthcare consists of three parts:

1. Setting national priorities and goals for performance improvement.
2. Endorsing national consensus standards for measuring and publicly reporting on performance.
3. Promoting the attainment of national goals through education and outreach programs (National Quality Forum, 2009).

In 2008 NQF convened the National Priorities Partnership (NPP) and it is one of its 28 members. The partners represent multiple stakeholders drawn from both the public and private sectors who have significant influence over healthcare and are committed to working together to deliver a high-value, high-performance healthcare system for all Americans. A list of members of the NPP is provided in Appendix A.

"The promise of our healthcare system is to provide all Americans with access to healthcare that is safe, effective, and affordable. But our system, as it is today, is not delivering on that promise. We must fundamentally change the ways in which we deliver care" (NPP, 2008, p. 7). Improving results will require focused efforts of patients, healthcare organizations, healthcare professionals, community members, payers, suppliers, government organization, and other stakeholders. As a first step, the partners identified a set of National Priorities and Goals to help focus performance improvement efforts on high-leverage areas, those with the most potential to result in substantial improvements in health and healthcare and to accelerate fundamental change in our healthcare system.

The overarching goals of the NPP are to eliminate harm, eradicate disparities, reduce disease burden, and remove waste. Hooper (2009e) stressed that overcoming these challenges must start with the individual nurse working within his/her own practice setting and specialty. Six priority areas were identified that the NPP partners believed, with combined and collective efforts, could have the most impact. These are:

1. Engage patients and families in managing their health and making decisions about their care.
2. Improve the health of the population.
3. Improve the safety and reliability of America's healthcare system.
4. Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.
5. Guarantee appropriate and compassionate care for patients with life-threatening illnesses.
6. Eliminate overuse while ensuring the delivery of appropriate care (NPP, 2008).

While these are aspirational goals, there have been successful small scale improvement projects that could provide direction on strategies to use on a national level. The rest of this independent study will focus on additional information on each of the six priorities, and information on work that has been done in these areas. It is up to those of us in all health care disciplines to take leadership in repairing this system (Hooper, 2009a).

Engaging patients and families in managing their health and making decisions about their care

The vision for this goal is to have a healthcare system that honors each individual patient and family, offering voice, control, choice, skills in self-care, and total transparency, and that can and does adapt readily to individual and family circumstances, and to different cultures, languages, and social backgrounds. (NPP, 2008)

National Priorities continued on page 8

Doctor of Nursing Practice (DNP)
• Post Masters (Online)
• Advanced Practice Nurse
• Nurse Executive
Master of Science in Nursing (MSN)
• Choose from 3 majors:
– Clinical Nurse Leader
– Family Nurse Practitioner
– Nurse Anesthesia
(7 semesters, full time)
ADN to MSN
• Family Nurse Practitioner
• Clinical Nurse Leader
QUESTIONS? CONTACT:
Dorothy Crider, MS, RN
(614) 823-3272
dcrider@otterbein.edu
www.otterbein.edu/graduatenursing

National Priorities continued from page 7

Strategies central to reaching this goal include asking all patients for feedback on their experience of care with the goal of improving that care, providing tools and support systems that enable patients to manage their care, and ensuring that all patients have access to information and assistance that enables them to make informed decisions about treatment options. Inherent in this is the ability of the healthcare provider to adapt to individual and family circumstances, culture, language, and social background.

Hibbard, Mahoney, Stock, and Tusler (2007) found that engaged patients, who seek out information about their condition and work collaboratively with their providers, are more likely to demonstrate health self-management behaviors (such as diet, exercise, and weight management) as well as disease-specific health management behaviors (such as keeping a diary of blood sugars when diagnosed with diabetes). Patients who are engaged as active partners in their healthcare team are vital to achieving better health outcomes, lower service utilization, and lower costs. An understanding of health management strategies can help patients avoid setbacks, which can lead to burdensome treatments and even hospitalization.

Professional caregivers can help patients become more engaged in their care. By seeking feedback on patients' and families' experiences of care, healthcare professionals can help improve quality and deliver care that is more patient-centered and responsive to their patients' needs. Patients can be empowered to take a more active role in their care when healthcare professionals provide the right kind of information and decision support, providing evidence-based recommendations, which patients can consider along with their personal values and preferences.

Weinstein, Clay, and Morgan (2007) found that when patients are fully aware of the risks and benefits, they may opt for care that is less invasive in nature, especially those patients with conditions that have multiple treatment alternatives and tradeoffs to consider. Other studies (O'Connor, Llewellyn-Thomas, & Flood, 2004) have shown that shared decision-making can reduce the number of patients choosing more invasive surgical procedures by 21 to 44 percent without adversely impacting health outcomes.

Other strategies that have been used include decision aids to help patients make the best decision, chronic disease self-management programs tailored to specific populations, and the requirement by the Centers for Medicare and Medicaid Services (CMS) that all hospitals use the Hospital Consumer Assessment of Healthcare Provider and Services (HCAHPS) survey instrument that has information about the hospital experience. This helps consumers compare hospital performance and get meaningful information for their own decision-making.

Making patient and family engagement a national priority will reduce harm by ensuring that patients understand their treatment options. In the United States, health literacy, the ability to obtain, process and understand information that is communicated regarding health status and healthcare, is poor, with only 12 percent of America's 228 million adults having the skills to manage their own healthcare proficiently. This includes weighing the risks and benefits of different treatments, knowing how to calculate health insurance costs, and being able to fill out complex medical forms (Only About 1 in 10, 2008).

Today almost 50 million Americans speak a language other than English at home, and 23 million have limited English proficiency (Flores, 2006). Health outcomes vary widely among different groups based on race, ethnicity, gender, socioeconomic status, and other variables. Tools and strategies that are culturally and linguistically appropriate can help reduce disparities.

Self-management programs which teach problem-solving skills can help patients better manage their care and reduce disease burden. These have been shown to be more effective than information-only patient education and have produced good outcomes in minority populations. Outcomes included improved health status, improved health behaviors, mental stress management, and reduced healthcare utilization in a Hispanic population (Lorig, Ritter, & Gonzalez, 2003).

Patients need a full understanding of all their treatment options, along with the benefits, risks, and tradeoffs associated with those options to make informed decisions about their care. There is growing evidence that patients who do receive this kind of decision support tend to make more conservative (and potentially less costly and less risky) decisions (NPP, 2008).

Goals to achieve this priority are:

1. All patients will be asked for feedback on their experience of care, which healthcare organizations and their staff will then use to improve care.
2. All patients will have access to tools and support systems that enable them to effectively navigate and manage their care.
3. All patients will have access to information and assistance that enables them to make informed decisions about their treatment options (NPP, 2008, 22).

Hooper (2009b) indicated that engaged health care providers should provide the patient/family with all available information, including outside resources, in a format that the consumer can understand. Equally important, however, is the engagement of the health care consumer. Consumers must, and should be encouraged to seek out independent information about their condition from multiple independent sources.

Strategies to assist students in developing the skills of engaging patients and their families must be incorporated into nursing curriculum. Assignments should be created that encourage students to talk with patients and their family to facilitate understanding of the client's point of view (Lewis, 2012).

Improve the health of the population

The vision for this goal is to have communities that foster health and wellness as well as national, state, and local systems of care fully invested in the prevention of disease, injury, and disability – reliable, effective, and proactive in helping all people reduce the risk and burden of disease (NPP, 2008).

With 60 percent of American deaths attributable to behavioral factors, social circumstances, and physical environmental exposures, we must ensure the optimal use of preventive services and superior clinical preventive care, provide support for healthy lifestyle behaviors, and address social and environmental issues that lead to poorer health outcomes (Kindig, Asada, & Booske, 2008).

The Partners believe that this work must take place at the community level, with national, state, and local involvement enabled through the development of stronger partnerships and coordination of care between the public health and healthcare delivery systems.

Making population health a national priority will reduce harm by encouraging preventive health screening and care. More than 1,500 Americans die from cancer each day, yet less than 50 percent of adults are up-to-date with colorectal cancer screening and only 67 percent of women have been screened for breast cancer in the past two years (Partnership for Prevention, 2007). Thirty six thousand people die and 200,000 are hospitalized annually due to complications from influenza, yet only 37 percent of adults over 50 years old get an annual flu vaccination. By immunizing 90 percent of adults over age 50 against influenza annually, approximately 12,000 additional lives could be saved each year (Partnership for Prevention, 2005).

Disparities would be reduced if everyone in the population received the same access and quality of care. Racial and ethnic minorities, and those in low income groups, face disproportionately high rates of disease, disability, and mortality (Institute of Medicine, 2002).

Tobacco use remains the leading preventable cause of death and contributes to the development of many serious diseases, including coronary heart disease, stroke, and peripheral vascular disease. There are 443,000 deaths in the United States attributed to cigarette smoking each year (CDC, 2009b). Likewise, being overweight leads to many other diseases, such as diabetes, hypertension and stroke. During the past 20 years there has been a dramatic increase in obesity in the United States. In 2008, only one state (Colorado) had a prevalence of obesity less than 20%. Thirty-two states had prevalence equal to or greater than 25%; six of these states (Alabama, Mississippi, Oklahoma, South Carolina, Tennessee, and West Virginia) had a prevalence of obesity equal to or greater than 30% (CDC, 2009a). Smoking cessation, good nutrition, and physical activity can help reduce the disease burden.

The ultimate goal is to reduce waste and ensure that all patients consistently receive the most effective recommended preventive services and do not receive tests for which there is poorly documented evidence of benefit. Merenstein, Daumit, and Powe (2006) found that unwarranted tests, based on U.S. Preventive Services Task Force recommendations, have been estimated to be ordered more than 40 percent of the time during annual health exams.

Strategies that have been implemented to achieve this goal include programs to ensure all members receive evidence-based preventive screening based on age and gender, reports summarizing the overall health of the community, nurse-managed, transdisciplinary health centers, and employer health and wellness programs.

Goals to achieve this priority are:

1. All Americans will receive the most effective preventive services recommended by the U.S. Preventive Services Task Force.
2. All Americans will adopt the most important healthy lifestyle behaviors known to promote health.
3. The health of American communities will be improved according to a national index of health (NPP, 2008, p. 26).

Hooper (2009c) asserted that sixty percent of American deaths can be attributed to behavioral factors, social circumstances, and physical environmental exposures that can be prevented or al least ameliorated through the optimization of preventive care and the promotion of health lifestyle behaviors. Government public health services provide the backbone for the provision of these essential services, but the need is too great for them to shoulder the burden alone. It will take all of us to make an impact.

For nursing students, strategies to address population health would center on activities that promote health and wellness in the community. Students should be introduced early in the curriculum how to find recommendations by the Agency for Healthcare Research and Quality and should also provide education about health lifestyles (Lewis, 2012).

Improve the safety and reliability of America's healthcare system

The vision for this goal is to have a healthcare system that is relentless in continually reducing the risks of injury from care, aiming for "zero" harm whenever possible – a system that can promise absolutely reliable care, guaranteeing that every patient, every time, receives the benefits of care based solidly in science. The Partners envision healthcare leaders and professionals intolerant of defects or errors in care who constantly seek to improve, regardless of their current levels of safety and reliability (NPP, 2008).

The Institute of Medicine (1999) found that each year more people die as a result of avoidable medical errors than they do from car accidents, breast cancer, or AIDS. Quality and safety vary from healthcare organization to healthcare organization. Although some hospitals have made significant strides in this area, overall there still is a performance gap in this area. The Agency for Healthcare Research and Quality (AHRQ) national data suggest that although our healthcare expenditures are growing at more than 7 percent per year, patient safety is improving at only 1 percent per year (AHRQ, 2007).

Critical to improving safety is the establishment of a "just culture" that supports the reporting of situations that threaten the safety of patients or caregivers and that view the occurrence of errors and adverse events as opportunities to make the healthcare system better.

Making safety a national priority will reduce harm by decreasing errors. According to Klevens, et al. (2007) approximately 1.7 million healthcare-associated infections (HAIs) occur annually in U.S. hospitals and are responsible for nearly 99,000 deaths. HAIs include, but are not limited to, catheter-associated bloodstream infections, surgical site infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia (VAP). HAIs in hospitals are a significant cause of morbidity and mortality in the United States.

Racial, ethnic, and socioeconomic minorities still do not receive equal care, and they face higher rates of disease, disability, and mortality resulting in part from a greater likelihood of suffering from avoidable errors that occur in the delivery of healthcare, For example, African Americans have higher rates for postoperative surgical and central venous catheter complications and are more likely to have adverse drug event associated with insulin or oral hypoglycemic; Hispanics and Asians have lower rates of appropriately timed antibiotics (AHRQ, 2007). Reducing disparities will improve safety.

Ventilator-associated pneumonias (VAPs), which in many cases are preventable, result in an estimated additional length of stay of nearly two weeks and an additional cost of $40,000 to a hospital admission. Leape and Berwick (2005) found that the use of a VAP bundle protocol may decrease VAP by 62 percent. This would certainly help reduce the disease burden.

Beyond the toll of human life, preventable errors have been estimated to cost the U.S. $17 billion to $29 billion per year in healthcare expenses, lost worker productivity, lost income, and disability (IOM, 1999). Serious adverse events include but are not limited to pressure ulcers, falls, blood product injuries, adverse drug events associated with high alert medications, wrong-site surgeries, air embolisms, and foreign objects retained after surgeries. If there were less errors, healthcare dollars spent to counter adverse drug events or to treat complications would be available for other interventions and we would reduce waste.

Strategies used to improve safety include reduction in door-to-balloon time for STEMI (ST-elevation-MI) patients, no payment for costs associated with preventable errors, surgical site infection prevention, public reporting of infection rates, and implementing various evidence-based interventions.

Goals to achieve this priority are:

1. All healthcare organizations and their staff will strive to ensure a culture of safety while striving to lower the incidence of healthcare-induced harm, disability, or death toward zero. They will focus relentlessly on continually reducing and seeking to eliminate all healthcare-associated infections and serious adverse events.
2. All hospitals will reduce preventable and premature hospital-level mortality rates to best-in-class.
3. All hospitals and their community partners will improve 30-day mortality rates following hospitalization for select conditions (acute myocardial infarction, heart failure, pneumonia) to best-in-class (NPP, 2008, p. 31).

Hooper (2009d) stressed that all health care providers must make patient safety the priority in all that we do. The reduction of patient errors and adverse events depends on all health care disciplines working together as a team to prevent the "swiss cheese" effect, when a human error results from a failure of many individuals and/or system and all the holes in the cheese line up, all back-up systems fail, and the error finds a direct line to the patient.

Lewis (2012) suggested the use of simulation as a teaching strategy can be used to create learning experiences without risk of patient harm. Students could demonstrate the ability to safely perform skills in the laboratory prior to patient care. It needs to be clear to the students that unsafe practice are not acceptable.

National Priorities continued on page 9

National Priorities continued from page 8

Ensure patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care

The vision for this goal is a healthcare system that guides patients and families through their healthcare experience, while respecting patient choice, offering physical and psychological supports, and encouraging strong relationships between patients and the healthcare professional accountable for their care (NPP, 2008).

Care coordination is a national priority as patients with multiple chronic conditions often receive care from numerous health care organizations in multiple care settings and may see up to 16 physicians annually (Bodenheimer, 2008). It is estimated that 157 million people in the United States will be living with at least one chronic illness and the number of individuals with multiple chronic conditions is expected to reach 81 million by 2020 (Anderson, 2008). As these patients navigate through the healthcare system and transition from one care setting to another, they are often unprepared to manage their care. Poor communication, incomplete transfer of information, and a lack of follow-up can lead to confusion and poor outcomes.

Care must be well coordinated to avoid waste, conflicting plans of care, and problems with medications, tests, and therapies. Medication reconciliation practices, which are now mandated by The Joint Commission, can have a positive impact on outcomes by reducing medication errors and adverse drug effects. According to Whittington and Cohen (2004), medication reconciliation practices have demonstrated reductions in medication errors by 70 percent and reductions in adverse drug events by more than 15 percent.

Having consistent access to the same healthcare professional over time is an essential element for care coordination and may be the most important factor in obtaining optimal preventive care. Both the cost of care and the potential for medical errors are greater when patients receive care from many healthcare professionals and do not have an identified and accountable primary source of care. Primary care practices that offer easy access to care, a long-term personal relationship with the primary care professional, integrated and comprehensive team care, and the coordination of specialty care and referrals may have the greatest potential to provide the level of care coordination that all Americans deserve (NPP, 2008).

Transition programs geared toward patients with chronic illness that include ongoing plans directed by advanced practice registered nurses to address discharge planning and home follow-up can decrease hospital readmissions, increase the length of time between discharge and readmission, increase patient and family satisfaction, decrease caregiver burden, and decrease healthcare costs (Naylor, et al, 2004).

Making care coordination a national priority will reduce harm by decreasing adverse events. According to Coleman and Berenson (2004) nearly one in five patients discharged from the hospital to home experience an adverse event within three weeks, and two-thirds of them are due to adverse drug events. Some of these require treatment in emergency departments and/or admission or transfer to another facility.

One way to reduce disparities is to improve primary healthcare services to reduce hospitalizations and emergency department visits. However there are still significant variations in access to primary care depending on race, income and insurance.

Nearly 18 percent of Medicare patients are readmitted to the hospital within 30 days, and 75 percent of those readmissions were identified as potentially preventable. Nearly 20 percent of patients' admissions to the hospital with a preventable admission had at least one preventable readmission within six months and emerging evidence suggests that many patients are not receiving timely follow-up visits with the primary care provider (NPP, 2008).

The cost to Medicare of preventable hospital readmissions that occur within 30 days of discharge is estimated to be upwards of $15 billion. For those 20 percent that have another preventable admission within six months, the costs skyrocket to $729 million, or $7,400 per readmission (MedPAC, 2007).

Strategies that have been used to meet this goal include transitional care models led by advanced practice nurses, emergency department classification systems, culturally-sensitive medication reconciliation programs for community residents, and disease management programs for specific diseases.

Goals to meet this priority are:

1. Healthcare organizations and their staff will continually strive to improve care by soliciting and carefully considering feedback from all patients (and their families, when appropriate) regarding coordination of their care during transition.
2. Medication information will be clearly communicated to patients, family members, and the next healthcare professional and/or organization of care, and medications will be reconfirmed each time a patient experiences a transition in care.
3. All healthcare organizations and their staff will work collaboratively with patients to reduce 30-day readmission rates.
4. All healthcare organizations and their staff will work collaboratively with patients to reduce preventable emergency department visits (NPP, 2008, p. 37).

Hooper (2010a) contended that the purpose of care coordination was to ensure that patients' needs and preferences for health care services are understood, and more importantly, that these preferences are communication as patients are moved from one health care setting to another, or from department/unit to another within a health care facility, or as care is shared between a primary health care provider and specialist.

The challenge with care coordination with prelicensure students, according to Lewis (2012), is they are still trying to grasp the basics of nursing care. Coordination requires a perspective of the complete picture of patient care and communication among health team members. We need to create more multidisciplinary experiences for students. Also educating them on the structured communication techniques such as situation-background-assessment-recommendation (SBAR) can assist them in speaking with other members of the team.

Guarantee appropriate and compassionate care for patients with life-limiting illnesses

The vision for this goal is to have healthcare capable of promising dignity, comfort, companionship, and spiritual support to patients and families facing advanced illness or death with all of the resources that community, friends, and family can bring to bear at the end of life (NPP, 2008).

Patients who are diagnosed with life-limiting illnesses and those facing the end of their lives deserve high-quality and compassionate care that addresses all of their needs. The American College of Physicians developed a clinical practice guideline (Qaseem, et al, 2008) with 5 recommendations, suggesting regular assessments for pain, dyspnea and depression, use of therapies with proven effectiveness to reduce pain, manage dyspnea and depression, and ensuring that advance care planning occurs for all patients with serious illness.

Palliative and hospice care programs give patients and family members the opportunity to help develop and guide care programs in a manner that is most comfortable for them and that meets their physical, social, and spiritual needs. Evidence suggests that patients enrolled in palliative care programs are more satisfied with their care and have fewer emergency room visits, fewer hospital and nursing facility days, and fewer physician visits than those in a comparison group. Enrolled patients in one study averaged a 45 percent decrease in costs as compared to usual care patients (Brumley, Enguidanos, & Cherin, 2003).

Making palliative and end-of-life care a national priority will reduce harm by preventing or alleviating suffering through an emphasis on effective pain management. Other symptoms, such as shortness of breath and depression, can also be managed through effective clinical support to prevent unnecessary distress. Although the use of hospice and palliative care services has increased in recent years, these services are still underutilized and many patients who could benefit from these services are never referred at all or are referred too late for the services to truly help (NPP, 2008).

In 2000, the vast majority of patients receiving hospice services were white (82 percent), 8 percent were identified as African-American, and 8 percent were Hispanic, indicating a clear disparity in the provision of end-of-life care. According to Jennings, Ryndes, D'Onofrio, and Bailey (2003) cultural, language, and religious differences may present barriers to appropriate referrals to palliative or hospice care, and difficult subjects regarding death and dying may not be adequately discussed.

On top of the losses experienced by their loved ones facing life-limiting illnesses or death, families and caregivers are confronted with emotional, physical, and economic challenges and need support to cope with added responsibilities. Caregivers can experience significant physical and psychological stress, contributing to a decline in their own health, and palliative care, with its holistic focus, has the potential to reduce this disease burden on family members and caregivers (NPP, 2008).

Approximately 25 percent of Medicare's expenses were paid for patients in their last year of life, and these expenses will continue to rise as we face an aging population (Hogan, Lunney, Gabel, & Lynn, 2001). Palliative care consultation teams have been associated with significant hospital savings. Patients receiving palliative care in the hospital who were discharged alive saw a net savings of nearly $1,700 in direct costs per admission and nearly $300 in direct costs per day (NPP, 2008).

Strategies to meet this goal include development of certification programs and core competencies in Hospital and Palliative Care, development of palliative care programs, having a consumer-focused website called Caring Connections and a New Hope program for children and adolescents who have lost a loved one, and the initiation of an End-Of-Life Nursing Education Consortium project.

Goals to meet this priority are:

1. All patients with life-limiting illnesses will have access to effective treatment for relief of suffering from symptoms such as pain, shortness of breath, weight loss, weakness, nausea, serious bowel problems, delirium, and depression.
2. All patients with life-limiting illnesses and their families will have access to help with psychological, social, and spiritual needs.
3. All patients with life-limiting illnesses will receive effective communication from healthcare professionals about their options for treatment; realistic information about their prognosis; timely, clear, and honest answers to their questions; advance directives; and a commitment not to abandon them regardless of their choices over the course of their illness.
4. All patients with life-limiting illnesses will receive high-quality palliative care and hospice services (NPP, 2008, p. 41).

Hooper (2010c) noted that patients facing life-limiting illnesses and end-of-life care deserve high level quality and compassionate care designed to support a comprehensive range of needs. This care should include plans to address the prevention and treatment of pain, assure continuity of care, support informed decision-making, and meet spiritual needs, all within the context of all available resources that the community, friends, and family can bring to bear. All nurses should do their part in assuring that this population gets the care and compassion that they deserve.

Nursing students should have the opportunity to explore palliative and end-of-life issues. Schools need to provide opportunities for caring for patients experiences the end of life; unfortunately many student do not experience dealth until after they have graduated from nursing school, leaving graduates ill-equipped to care for this population of patients and their families (Lewis, 2012)

Carlson (2010) quoted Panicola, the ethics executive at SSM Health Care, who stated that "end-of-life care is fraught with complexities and difficulties, but we need to focus on better communication. Palliative care is an option. But the people who are caring for seriously ill and dying patients need to have time to have conversations with patients in how to meet their goals."

Eliminate overuse while ensuring the delivery of appropriate care

The vision for this goal is to have healthcare that promotes better health and more affordable care by continually and safely reducing the burden of unscientific, inappropriate, and excessive care, including tests, drugs, procedures, visits, and hospital stays (NPP, 2008).

Although a significant amount of attention on healthcare focuses on the care that Americans do not receive, there is growing evidence that a significant portion of the care we receive is actually redundant and unwarranted, and sometimes even harmful. Researchers at the Dartmouth Medical School (Fisher, et al, 2003) have shown there is significant variation in healthcare spending between regions of the United States, only 40 percent of which can be attributed to different rates of illness and price. The remaining variation can be explained by practice variations that have little to do with evidence-based medicine, but rather with the capacity to provide healthcare. Areas with more specialists have more consultations and consequently provide more surgeries and procedures and have higher expenditures, regardless of whether such care is warranted.

The idea that "more does not necessarily mean better" is starting to resonate outside the quality community and is entering into broader public consciousness. A book by Brownlee (2007) on this topic was read by millions , and many news outlets and national consumer organizations, including the *New York Times, U.S. News & World Report, the Wall Street Journal,* AARP and Consumers Union, all ran articles that have increased public awareness of this issue (NPP, 2008).

Making overuse a national priority will reduce harm by avoiding the inappropriate use, misuse, or overuse of medical interventions, such as inappropriate use of antibiotics, unwarranted surgeries and procedures, and unnecessary testing. Beyond the negative impact of wasted resources that we can ill afford, the areas of inappropriate use identified may cause unnecessary harm to millions of Americans (New England Healthcare Institute [NEHI], 2009). The NEHI call to action included doing a better job of controlling costs by preventing illness, managing chronic disease, and strengthening primary care for all Americans.

Effectively addressing the burden of unnecessary care is one way to remedy the problem of disparities in how care is and is not provided. The discussion of healthcare disparities typically focuses around the lack of access to services and the lack of appropriate care; however, assuring access to appropriate healthcare services early on can also help to reduce more costly utilization downstream. Studies have indicated that the overutilization of emergency departments and unnecessary hospitalizations are more common in minority populations (NPP, 2008).

There were several examples provided of ways to help reduce disease burden. The rising number of cesarean sections can have long-term unintended consequences for women and their offspring. Women who have c-sections are at increased risk for chronic pelvic pain, bowel obstruction, and complications of pregnancy. On the other end of the spectrum approximately 20 percent of patients are given chemotherapy in the last 14 days of life (Murillo & Koeller, 2006), at which point the disease has progressed to such an extent that the chemotherapy has essentially no chance of helping.

According to Dartmouth research (Dartmouth Atlas Project, 2007), individuals who live in "high-spending" areas receive approximately 60 percent more in services

National Priorities continued on page 10

National Priorities continued from page 9

than those who live in "low-spending" areas. Furthermore, the low-spending regions perform as well or better on a range of quality indicators. Reducing preventable hospitalizations by 5 percent for ambulatory care–sensitive conditions could result in savings of more than $1.3 billion (AHRQ, 2000).

Strategies to meet this goal include decision support tools embedded in electronic medical records, "advanced notification" programs requiring physicians to get pre-approval for tests, homecare interventions and monitoring to prevent readmissions, and information to consumers on the issue of overuse and potential dangers of inappropriate medical care (NPP, 2008).

Goals to meet this priority are:

All healthcare organizations will continually strive to improve the delivery of appropriate patient care and substantially and measurably reduce extraneous service(s) and/or treatment(s). There are nine recommended areas of concentration:

1. Inappropriate medication use, targeting antibiotic use and polypharmacy.
2. Unnecessary laboratory tests, targeting panels and special testing.
3. Unwarranted maternity care interventions, targeting cesarean section.
4. Unwarranted diagnostic procedures, targeting cardiac and chest computed tomography, lumbar spine magnetic resonance imaging, bone or joint x-rays, endoscopy, and admission or routine monitoring.
5. Inappropriate nonpalliative services at the end of life, targeting chemotherapy in the last 14 days of life, aggressive interventional procedures, and more than one emergency department visit in the last 30 days of life.
6. Unwarranted procedures, targeting spine surgery, percutaneous transluminal coronary angioplasty/ stent, knee/hip replacement, coronary artery bypass graft, hysterectomy, and prostatectomy.
7. Unnecessary consultations.
8. Preventable emergency department visits and hospitalizations, targeting potentially preventable visits, hospital admissions lasting less than 24 hours, and ambulatory care-sensitive conditions.
9. Potentially harmful preventive services with no benefits, targeting BRCA mutation testing for breast and ovarian cancer, coronary heart disease screening for low risk patients, carotid artery stenosis screening, cervical cancer screening for females over 65 years, and prostate cancer screening for males of 75 years (NPP, 2008, p. 47).

Ballard and Leonard (2011) reported significant variability in the application of cardiac revascularization, and suggested using concurrent data collection tools to support real-time clinical decision making regarding appropriateness of treatment, as well as financial incentives and public reporting of performance information.

According to Hooper, (2010b) sixty percent of the variation in health care spending in the US can be attributed to practice variations having little or nothing to do with different rates of illness, price, or evidence-based practice recommendations. Evidence, in association with patient preference and provider expertise must drive health care decisions.

Lewis (2012) outlined many possibilities for assisting students in understanding the concept of overuse. If students follow a home-care or telehealth nurse can they better understand how these nurses assist clients in maintaining a state of health and prevent rehospitalization. Students should also be taught how to access and critically read literature in support of evidence-based practice.nts.

National Priorities Partnership recognizes the only way to achieve the bold goals they have set is for all partners to take bold actions. There are a handful of extremely effective mechanisms that can truly drive change in the healthcare system: performance measurement, public reporting, payment systems, research and knowledge dissemination, professional development, and system capacity. These require leadership and commitment to support change at the federal, state, and local levels, and working together to achieve the goals (NPP, 2008).

In each of these areas, guidelines were outlined for the selection of measures. For performance measurement, they were:

1. Measures should be linked directly to the national priorities and goals.
2. Measures should have a clear and compelling use.
3. Measures should be parsimonious and not impose undue costs or burden on those providing data.
4. Measures should balance the need for continuous improvement with the stability needed to track progress over time.

For public reporting, they were:

1. Measures should be meaningful to consumers and reflect a diverse array of healthcare professionals' clinical activities.
2. Those being measured should be actively involved.
3. Measures and methodology should be transparent and valid.
4. Measures should be based on national standards to the greatest extent possible.

For payment systems, they were:

1. Payments should be tied to results.
2. Systems should foster appropriate care and stewardship of resources.
3. Payments should support coordination, integration, and delivery capacity.
4. Programs should be simple and understandable.
5. Patients should get the right incentives.
6. Programs should encourage evidence-based care, while fostering innovation.

For research and knowledge dissemination, they were:

1. The national priorities and goals should inform the research agenda – basic science, clinical, and translational, specifically the research agenda should build the evidence base for knowing what works and for whom, and for how to best translate this knowledge into routine practice.
2. Infrastructure should be in place so that there is the capacity for rapidly and reliably disseminating best practices as well as a feedback loop for ongoing learning and monitoring for unintended consequences.

For professional development education and certification, they were:

1. Provide patient-centered care;
2. Work in interdisciplinary teams;
3. Employ evidence-based practice;
4. Apply quality improvement; and
5. Utilize informatics (NPP, 2008, p. 49-54).

Reiger (2010) emphasized the importance of everyone working towards meeting these priorities. For instance, for the priority of overuse, if all nurses could identify and eliminate one type of "waste" in their institution, such as a repeated diagnostic test simply because the report of the previous one was unavailable what a difference could be made.

A group of nurse executives partnered with the Robert Wood Johnson Foundation (RWJF) to present a two-day invitation workshop in October of 2009 (Jennings & Lamb, 2011). The workshop was designed to achieve 3 goals. The first goal was to assess nursing's current and future contributions to the NPP agenda. The second goal was to advance and accelerate the achievement of the NPP goals. The last goal was to propose recommendations that could be used by the nursing community as an action plan to advance the NPP agenda. The importance of involving frontline staff – clinicians- in transforming care was a theme throughout the workshop. Nurse executives must ensure there is an infrastructure to support this work.

Other recommendations that came out of this workshop were that the nursing community would:

1. Increase nursing's visibility and value to key stakeholder groups, especially consumers and purchases;
2. Expand the set of nurse sensitive measures and their inclusion in public reporting;
3. Achieve payment for effective nurse-led care delivery models consistent with the NPP goals; and
4. Increase funding for research that links nurse interventions to outcomes for patients and healthcare systems. (Jennings & Lamb, 2011, p. 151)

Lewis (2012) noted that nursing educator leaders face a real challenge in trying to teach students that are ready to meet the needs of a rapidly changing health care system. Creating benchmarks will be necessary to evaluate the effective of the new strategies implemented throughout the curriculum. Measuring performance outcomes with regard to students knowledge, attitude, and skill in regard to patient and family engagement, population health, safety, care coordination, palliative and end-of-life care, and overuse will assist in program evaluation and identify areas that need modified.

All team members and partners must work together for safety quality outcomes. Every American, regardless of economic, social, or cultural class, deserves high quality healthcare. As nurses, we need to be aware of initiatives to transform health care and need to embrace transparency, public reporting, and best-in-class measures of performance to work on achieving the national priorities and goals. Benefits will include engaged patients and families managing their health and health-care decisions, improved health of the population, improved safety and reliability of the health care system, as well as patients receiving well-coordinated care within and across all healthcare organizations and settings.

Appendix A
Partners in National Priorities Partnership
(Listed in Alphabetical Order)

Agency for Healthcare Research and Quality (AHRQ)	Alliance for Pediatric Quality (APQ)
American Association of Retired Persons (AARP)	American Board of Medical Specialties (ABMS)
American Federation of Labor-Congress of Industrial Organizations (AFL-CIO)	American Nurses Association (ANA)
Assessment and Qualifications Alliance (AQA)	Center for Health Care Reform, Brookings Institution
Centers for Disease Control and Prevention (CDC)	Centers for Medicare and Medicaid Services (CMS)
Certification Commission for Healthcare Information Technology (CCHIT)	Commission for Performance Improvement (CPI)
Consumer Reports Best Buy Drugs	HealthPartners, representing America's Health Insurance Plans
Hospital Quality Alliance (HQA)	Institute for Healthcare Improvement (IHI)
Institute of Medicine (IOM)	Leapfrog Group
National Association of Community Health Centers (NACHC)	National Business Group on Health
National Committee for Quality Assurance (NCQA)	National Governors Association
National Heart, Lung, and Blood Institute, National Institutes of Health (NHLBI-NIH)	National Partnership for Women and Families
National Quality Forum (NQF)	Pacific Business Group on Health
The Joint Commission (TJC)	U.S. Chamber of Commerce

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EOE

National Priorities continued on page 11

National Priorities Partnership

Post-Test and Evaluation Form

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per question. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Name:____

Date:_____________________ **Final Score:** __________

Please circle one answer.

1. Which country spends more per capita on healthcare than any other industrialized country?
   a. Japan
   b. United States
   c. Canada
   d. Great Britain

2. The organization that convened the National Priorities Partnership (NPP) is
   a. National Committee for Quality Assurance
   b. The Joint Commission
   c. Institute for Healthcare Improvement
   d. National Quality Forum

3. Which is of following is NOT one of the overarching goals of the NPP?
   a. Eliminate harm
   b. Eradicate disparities
   c. Increase disease burden
   d. Remove waste

4. Strategies to engage patients and families in managing their health and making decisions about their care include:
   a. Asking all patients for feedback on their experience of care
   b. Providing tools and support systems that help patients manage their care
   c. Ensuring all patients can make informed decisions about treatment options
   d. All of the above

5. Self management programs which teach problem-solving skills have been shown to be more effective than information-only patient education.
   a. True
   b. False

6. The vision for improving the health of the population envisions communities that foster health and wellness and the prevention of disease, injury and disability.
   a. True
   b. False

7. What percent of American deaths are attributable to behavioral factors, social circumstances, and physical environmental exposures?
   a. 50 percent
   b. 55 percent
   c. 60 percent
   d. 65 percent

8. Strategies to help reduce the disease burden include ALL but which of the following:
   a. Smoking cessation
   b. Good nutrition
   c. Mandatory health screenings
   d. Physical activity

9. According to the Institute of Medicine, which of the following is responsible for the most deaths each year?
   a. Car accidents
   b. Breast cancer
   c. AIDS
   d. Medical errors

10. Improving the safety and reliability of America's healthcare system includes having a healthcare system that continually looks for ways to increase the risks of injury from care and encourage defects.
    a. True
    b. False

11. Strategies to improve safety include ALL but which of the following:
    a. Aiming for "zero" harm
    b. Establishing a culture of safety
    c. Surgical site infection prevention
    d. Paying for preventable medical errors

12. Ensuring that patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care requires a healthcare system that guides patients and families through their healthcare experience.
    a. True
    b. False

13. Care coordination is enhanced by:
    a. Poor communication
    b. Incomplete transfer of information
    c. Physical and psychological supports
    d. Lack of follow-up

14. Transition programs geared toward patients with chronic illness that address discharge planning and home follow-up can do all of the following EXCEPT:
    a. Decrease hospital readmissions
    b. Decrease the length of time between discharge and readmission
    c. Increase patient and family satisfaction
    d. Decrease caregiver burden

15. Nearly 18 percent of Medicare patients are readmitted to the hospital within 60 days and 55 percent of those readmissions were identified as potentially preventable.
    a. True
    b. False

16. Guaranteeing appropriate and compassionate care for patients with life-limiting illnesses ensures dignity, comfort, companionship and spiritual support to patients and families facing advanced illness or dying.
    a. True
    b. False

17. The American College of Physicians developed clinical practice guidelines with recommendations for individuals facing the end of their lives. These included all of the following EXCEPT:
    a. Regular assessments for pain, dyspnea, and depression
    b. Use of experimental therapies to reduce pain
    c. Ensuring advanced care planning occurs
    d. Management of dyspnea and depression

18. Palliative care teams have contributed to fewer emergency room visits, fewer hospital and nursing facility days and fewer physician visits by:
    a. Meeting physical, social, and spiritual needs
    b. Emphasizing cultural, language and religious differences
    c. Increasing disease burden on caregivers
    d. Withholding information about treatment options

19. Eliminating overuse includes a healthcare system that reduces the burden of unscientific, inappropriate and excessive care.
    a. True
    b. False

20. Examples of inappropriate medical interventions include all of the following EXCEPT:
    a. Inappropriate use of antibiotics
    b. Unwarranted surgeries and procedures
    c. Decision support tools in electronic medical records
    d. Unnecessary testing

21. There were 5 recommended areas of concentration to eliminate overuse, including medications, tests, C-sections, and diagnostic procedures:
    a. True
    b. False

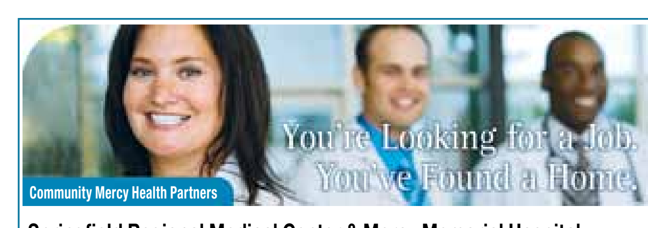
Evaluation

		YES	NO
1.	Were you able to achieve the following objectives?		
	a. Define the National Priorities Partnership and the National Priorities and Goals.	___ Yes	___ No
	b. Identify strategies to achieve goals of eliminating harm, eradicate disparities, reduce disease burden and remove waste.	___ Yes	___ No
2.	Was this independent study an effective method of learning?	___ Yes	___ No

If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?

4. What other topics would you like to see addressed in an independent study?



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The Board's Disciplinary Authority: What Does It Mean & How Does It Happen?

Developed by: Janice K. Lanier, RN, JD.
Updated by Kathleen Morris, MSA, RN

The authors and planning committee members have declared no conflict of interest. Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice or to be a comprehensive compendium of evidence-based practice. For specific implementation information, please contact an appropriate professional, organization, legal source, or facility policy.

INDEPENDENT STUDY

This independent study has been developed to enhance the nurse's knowledge about the Ohio Board of Nursing's disciplinary authority and process. 1.3 contact hour of Category A (Law and Rules) will be awarded for successful completion of this independent study.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

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OBJECTIVES

1. Describe activities that could lead to Board action.
2. Identify the processes used by the Board to take action.

"Can the Board really take away my license to practice as a nurse? Forever?"

"Can the Board really tell me I can't work in certain practice areas?"

"How can that happen?"

Indeed the Board of Nursing (Board) can do those things and more, but it does so only in accordance with specific laws and rules governing its actions and authority. The purpose of this independent study is to provide information about the extent of the Board's authority with respect to disciplinary matters. **Upon successful completion a nurse will be able to describe activities that could lead to Board action and identify the processes used by the Board to take action.** The study will briefly present background information with respect to the Board's overall authority and then focus in more detail on provisions in the law that address its disciplinary role and responsibilities. This study is not intended to provide legal advice. A nurse facing possible Board action should contact his/her own legal counsel.

Background Information

Because of the potential for harm associated with the kinds of duties nurses were performing, the Ohio legislature (the General Assembly) in 1915 established a committee under the auspices of the state medical board to regulate nursing practice. While the name of the Board and many of its functions (including its independence from the medical board) have evolved over time, the sole reason for its existence remains unchanged – to protect the public from incompetent practice. While originally established to oversee the practice of registered nurses and eventually licensed practical nurses, the Board[1] now has jurisdiction over advanced practice nurses, dialysis technicians, certified community health workers and certified medication aides.

(Although this study uses the term "nurse" throughout, the concepts included apply to any practitioner recognized by law as coming under the Board's authority).

Many mistakenly believe the Board's purpose is to provide practice guidance and other assistance to its licensees. That is not the rationale underlying the establishment of any regulatory board. Rather, public protection is the only role these boards are intended to fulfill. The Board of Nursing's mission statement says it very succinctly. The purpose of the Board is to "actively safeguard the health of the public through the effective regulation of nursing care." It is critical for nurses and others to understand this public protection mandate so as to have realistic, accurate expectations regarding what the Board can or cannot do for them.

The Board meets the expectations set forth by the General Assembly in several ways. First it has authority to approve and re-approve pre-licensure nursing education programs (and training programs for its other certificate holders) in order to ensure potential nurses have the basic preparation they need to be minimally competent, safe practitioners. The Board also determines whether those individuals seeking licensure or certification and re-licensure/re-certification to practice in Ohio meet certain criteria such as completion of an approved education or training program and ongoing continuing education. Potential licensees must also pass a criminal background check. Once an individual is licensed or applies to the Board for licensure, the Board has authority to take action should it determine that the laws regulating practice may have been violated. In other words, the Board is charged with enforcing Chapter 4723 of the Ohio Revised Code as enacted by the legislature and the rules adopted under that chapter by the Board itself – Chapters 4723-1 through 4723-27 of the Ohio Administrative Code. This authority exists for as long as someone is licensed or is eligible for licensure by the Board. That means a nurse who places his/her license on inactive status can still be the subject of Board action even without holding a current active Ohio license.

> *Key concepts:*
> The Board protects the public by:
> - ensuring that would-be nurses are appropriately educated;
> - that they meet licensure/re-licensure criteria; and
> - that they practice in accordance with laws and rules designed to ensure competent safe care.

While the law establishes the Board's authority, it also places limits or restraints on the extent of the Board's reach. Board actions must be consistent with the law. In other words, the law identifies the kinds of behaviors that could result in Board action and also sets out the processes the Board must follow for taking such action. If it is not in the Nurse Practice Act (Chapter 4723 of the Revised Code) it is outside the Board's authority. The Board is bound to uphold these legal provisions and failure to do so could nullify any action it might take. Further, the Board has jurisdiction only over the individuals or entities it regulates. That means the Board has authority only over pre-licensure nursing education programs not graduate programs or completion programs. The Board does not have authority over employers such as hospitals, nursing homes, or home health agencies nor can it take action against imposters who practice nursing without a license. These latter individuals must be referred to county law enforcement because the unlicensed practice of nursing is a criminal offense.

In light of these limitations and considerations – what is the extent of the Board's activities with respect to its disciplinary responsibilities? Generally, the number of complaints received by the Board has increased significantly as have the number of disciplinary actions taken. As a result, the Board directs a significant portion of its resources toward its compliance functions. According to the Board's annual reports to the governor,[2] in 2012, 51% of its staff members were part of the compliance unit. In 2012, the Board utilized one enforcement agents, seven adjudication coordinators, seven compliance agents, two supervising attorneys, and six monitoring agents to deal with the 7,298 complaints it received. The Board took action in 2,076 cases. Since 2003 the number of complaints has more than quadrupled. (See figure 1) Clearly it is disturbing to see data indicating so many nurses are running afoul of the Board and potentially endangering the public. While not something to ignore, one must also note that there are over 256,000 individuals regulated by the Board of Nursing so the number of actions represents a small percentage of its licensees. In addition, many of the actions involve repeat offenders, which mean relatively few individuals may be accounting for much of the Board's work.

Figure 1

Year	Complaints[3]	Action
2003	1,817	
2006	3,399	
2007	3,705	On average 200 actions were taken at each of 6 meetings
2008	4,021	On average 208 actions were taken at each 6 meetings
2009	5,501	
2010	6,144	Action taken in over 2,000 cases
2011	6,880	Action taken in over 2,000 cases
2012	7,298	Action taken in over 2,000 cases

With this background information in mind it is time to turn to the section of the Nurse Practice Act that sets out the Board's disciplinary authority – Section 4723.28 of the Revised Code and the related rules in Chapter 4723-16 of the Ohio Administrative Code (OAC).

First and foremost, Board action is not taken in secret. "Due process" must be provided before taking action in most situations.[4] Due process means the Board must (1) inform the nurse of the section(s) of the law or rules he/she is alleged to have violated and how those violations occurred; and (2) provide an opportunity for the nurse to be heard – to tell his/her side of the story.

Due process, while affording a measure of protection for the nurse, is not without its limits. The law sets out requirements as to how this notice is to be provided – via certified mail or regular mail with a certificate of mailing (Rule 4723-16-01 OAC). If a nurse fails to pick up the mailing the Board may use other means (publication in a newspaper of general circulation for example) to issue its notice.

The nurse may or may not actually receive the notice provided via one of the alternatives. Regardless, through its actions the Board has met its statutory notice obligations. In addition, the opportunity to be heard has certain procedural considerations that affect a nurse's due process rights. The notice details the time frames during which the nurse may respond and request a hearing. A nurse's failure to adhere to the time frames means the opportunity to present evidence refuting the Board's charges is lost. The law does not allow the Board to use its discretion with respect to waiving the notice requirements.

> ***Key concepts – Due Process***
> *Due Process includes:*
> * *The right to notice of the charges against you and*
> * *The right to be heard – to tell your side of the story*
> *A nurse can forfeit those rights by failing to adhere to the time frames specified in the notice. Ignoring the notice does not make it go away.*

What actions can the Board take?

The Board is authorized by law to permanently revoke a license or certificate, which means the individual, is forever prohibited from receiving the documents needed to engage in practice. Returning to school, repeating the licensure examination or any other actions will not result in a return of the authority to practice. The Board may also suspend a license for a specified period. The license is not lost forever; but the individual may not engage in activities constituting the practice of nursing until certain requirements are satisfied. The extent of those requirements varies depending on the situation leading to the Board's action. The Board may also place restrictions on one's license, again tailored to reflect the circumstances that led to the disciplinary action. The Board may, for example, prohibit practice in an area where supervision is not readily available or with a certain category of patients (the elderly or children) or the nurse may not be allowed to administer controlled substances. Restrictions may be temporary or permanent.

Additionally, the Board may reprimand a nurse, impose a fine of not more than $500 per violation, or take other actions such as requiring community service or additional continuing education. The extent of the discipline is intended to reflect the circumstance surrounding the offense itself. Regardless of the sanction, disciplinary action is permanent and follows the nurse wherever he/she goes. It can affect one's professional life in untold ways and should always be taken seriously by the nurse. Sadly many nurses are not aware, until too late, of the fallout that accompanies Board action regardless of its severity.

Section 4723.28 – What does it say?

From the outset, the law signals the importance of honesty in one's dealings with the Board. The Board may revoke or refuse to grant a license – the most serious sanction available – to someone who has committed fraud, misrepresentation, or deception in applying for or securing a license or certificate. (Section 4723.28 (A) ORC). When applying for a license or certificate or when renewing those documents, the applicant is asked to respond to a series of questions, the answers to which may be uncomfortable,

The Board's Disciplinary continued on page 13

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The Board's Disciplinary continued from page 12

depending on the circumstances. Some might be tempted to be less than honest with the responses; however, if one does not answer forthrightly, the Board may revoke or refuse to grant the license solely on the basis of the deception without regard for the circumstances that prompted the response.

Applying the law:

A nurse applying for re-licensure finds that the application includes a question as to whether she had been convicted of a felony during the preceding two years. The nurse had experienced family issues due to a pending divorce and as a result had recently been convicted of a domestic violence offense, categorized as a felony of the 4th degree. Because she believed she had been wrongly convicted and fearing the consequences if she answered "yes," the nurse responded "no" to the question. The Board subsequently received notice of the nurse's conviction from the county prosecutor in accordance with Section 4723.34 of the Revised Code and immediately initiated action against her. The nurse tried to explain the circumstances leading to the domestic violence conviction only to learn that the Board's allegations concerned deception in applying for licensure to which she had no defense or response. Without regard to the circumstances surrounding the conviction, the Board voted to permanently revoke the nurse's license – a result the nurse did not anticipate. Had she been honest in her response, she would have faced Board charges related to the conviction, but she could have had an opportunity to explain the circumstances leading to the conviction and perhaps faced a less onerous sanction.

In addition to the language addressing fraud or deception, the law contains thirty-three (33) actions that can lead to Board of Nursing sanctions. If something is not included in this list the Board has no authority to take action. For example, an employer may threaten to report a nurse to the Board if he/she refuses to work mandatory overtime. Nothing in the law addresses employment issues such as this; therefore, the Board has no grounds to take action on the basis of this kind of complaint. The nurse may face action by the employer, however.

Following is an overview of the so-called .28 actions that can lead to Board sanctions. (The list is not exhaustive and should not be considered a substitute for the actual statutory language).

- **Action taken by another state for any reason other than failure to renew a license.** A nurse need not engage in practice in Ohio to find his/her practice restricted or prohibited here because of something that occurred elsewhere. Ohio's sanction may be the same as or different from the one imposed originally. This provision is intended to prevent nurses whose practice is suspect from moving from state-to-state and engaging in potentially unsafe practice everywhere he/she goes. Most states have similar language in their practice acts.
- **Engaging in practice while a license is under suspension or lapsed.** An individual must hold a current valid license to engage in nursing practice. Otherwise it is considered the unauthorized practice of nursing, which is a criminal offense. A nurse who fails to renew his/her license biennially would violate this provision by practicing nursing during the time the license is lapsed.
- **Conviction of, a plea of guilty to, a judicial finding of guilt even if it stems from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for a misdemeanor committed in the course of practice in Ohio or elsewhere.** Note: A misdemeanor charge without a conviction or judicial finding does not provide grounds for Board action. Also if the conviction involves an offense considered a misdemeanor, it must occur in the course of practice. Typically, driving under the influence (DUI) is a misdemeanor that is not committed in the course of practice; therefore, the Board generally does not have authority in these circumstances.
- **Conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for any felony or crime involving gross immorality or moral turpitude in Ohio or elsewhere.** Several factors should be noted with respect to this provision. Again, the law does not apply simply because one has been charged with a felony. There must be a conviction, guilty plea, or judicial finding in order to trigger the Board's jurisdiction. The law, however, does not limit the offense to one that is committed in the course of practice. Rather any felony, or act in another jurisdiction considered a felony in Ohio, would give rise to Board action. Finally a crime of "moral turpitude" while hard to define is not limited to felonies. It is possible, therefore, for a pattern of repeated convictions based on misdemeanor offenses to be considered "moral turpitude" and hence fall within the Board's authority.
- **Selling, giving away, or administering drugs or therapeutic devices for other than legal and legitimate therapeutic purposes or conviction of, a plea of guilty to, a judicial finding of guilt of, a judicial finding of guilt resulting from a plea of no contest to, or a judicial finding of eligibility for intervention in lieu of conviction for violating any municipal, state, county, or federal drug law.** Most licensees recognize that selling drugs for other than legal purposes violates nursing law; however, giving away or administering these drugs or devices also violates the law. Nurses may be tempted to help out a friend by giving him/her pain medication that was originally prescribed for the nurse. Doing so places the nurse at risk for licensure action by the Board regardless of the motivation for his/her actions.
- **Self- administering or taking any drug in any way not in accordance with a valid prescription issued for that individual.** This provision could surprise the nurse who is unaware of how all-encompassing the law is with respect to use of prescription drugs. A nurse who takes a medication that is not prescribed for him/her risks Board action regardless of the circumstances. While some may believe the provision is limited to controlled substance, that is not the case.
- **Habitual indulgence in the use of controlled substances, other habit-forming drugs, or alcohol or other chemical substances to an extent that impairs one's ability to practice.** Even if a nurse is taking controlled substances in accordance with a valid prescription, he/she could still face Board action if the ability to practice is negatively affected as a result. The practice impairment applies to the use of alcohol as well. Simply having a substance abuse problem does not trigger Board action unless the Board can prove it has practice related implications.
- **Impairment of the ability to practice in accordance to acceptable and prevailing standards of safe nursing care because of habitual or excessive use of drugs, alcohol, or other chemical substances that impair the ability to practice.** While seemingly a repeat of the above provision, there are subtle differences. This language does not state that the drugs at issue are controlled substances or habit-forming. Rather, any drug or alcohol usage that impairs practice could lead to Board intervention. Further this provision includes excessive use of these drugs that may not be considered "habitual."
- **Impairment in the ability to practice according to acceptable and prevailing standards of safe nursing care because of a physical or mental impairment.** If a nurse has a physical or mental impairment, the impairment alone does not provide grounds for Board action. The Board must prove that the impairment affects the nurse's ability to practice safely—a subtle but important distinction when building a case for or against the nurse.
- **Adjudication of mental illness or mental incompetence.** The authority to practice can be restored when proof of competence is demonstrated either to a court or the Board.
- **Assaulting or causing harm to the patient or depriving the patient of the means to summon assistance.** It should come as no surprise that harming a patient could result in sanctions by the Board; however, depriving the patient of the means to summon assistance raises interesting scenarios. Generally, a nurse who is providing care in an institutional environment would find it difficult to leave a patient at such a disadvantage; however, nurses in community or home health settings should be conscious of this provision.
- **Obtaining or attempting to obtain money or anything of value by intentional misrepresentation or material deception in the course of practice.** While seemingly obvious on its face, this provision applies to intentional/material actions by the nurse. That means the Board must prove the nurse possessed the required intentional mental state and that the deception was substantial in nature.
- **Failure to practice in accordance with acceptable and prevailing standards of safe care, including failure to use universal blood and body fluid precautions.** These provisions were added to the law so as to make it possible for the Board to take action when a nurse's practice is sloppy or of a nature to potentially endanger patients. Prior to the adoption of this language, the Board had authority to take action if the nurse's practice was impaired due to substance abuse or mental disability but if the Board learned a nurse was simply committing practice errors unrelated to impairment or abuse, it was powerless to take action. That situation changed in the early 1990's when the General Assembly revised the law to include this new provision. The law does not specify the acceptable standards of practice. Rather, it gave the Board authority to adopt a series of rules specifying the expectations in greater detail. (Chapters 4723-4, 4723-13, and 4723-20 OAC contain these rules.)
- The rules include, in part, provisions addressing competence, accountability, and patient safety considerations, including standards for delegation, documentation, and implementation of physician orders. While the majority of Board actions are based on substance abuse issues, a significant number of actions are a result of practice-related violations.
- **Failure to establish and maintain professional boundaries.** This provision is another relatively new addition to Section 4723.28 ORC that was included by the legislature when the Board identified an increased incidence of behaviors by its licensees that seemed to constitute inappropriate involvement in the personal lives of patients—borrowing money, accepting loans or costly gifts for example. Boundary violations also include sexual conduct with a patient as well as verbal behavior that are sexually demeaning or may reasonably be interpreted by the patient as demeaning. For purposes of this provision, the patient is considered incapable of consenting to this conduct.
- **Aiding and abetting in the unlicensed practice of nursing.** If a nurse allows someone to engage in activities that constitute the practice of nursing without holding a license, the nurse could face disciplinary action by the Board. For example, a nurse in an administrative position could run afoul of this provision if he/she were to employ or contract with an individual who purports to be a nurse expecting them to function as a licensed nurse and then fail to verify the individual's licensure status.
- **Practicing outside one's authorized scope of practice.** The law contains definitions setting forth what constitutes the practice of nursing by registered nurses, licensed practical nurses, and advanced practice nurses. It also prohibits the practice of medicine or surgery, except to the extent advanced practice nurses are authorized to do so within specific statutory provisions. Despite what some believe, a nurse's scope of practice is NOT whatever a physician or others says it is. Nurses must adhere to the provisions in Section 4723.01 of the Revised Code that define nursing practice. Failure to do so could lead to Board action.
- **Violation of this chapter or any rules adopted under it.** This catch-all phrase allows the Board considerable leeway to deal with a variety of actions that could have a negative impact on the public's safety. For example, the law requires employers of nurses to report to the Board anytime a current or former employee engages in conduct that would be grounds for disciplinary action under Chapter 4723 of the Revised Code. (Section 4723.34 ORC). While this reporting requirement provision is not contained in Section 4723.28, it does establish obligations for the employer who is also a nurse. Similarly, the law provides protection for certain titles including registered nurse (RN), licensed practical nurse (LPN) and advanced practice nurse (APN). (Section 4723.03 ORC). Only individuals holding a current valid license (not an inactive or lapsed license) to practice nursing issued by the Board may use those protected titles.
- **Assisting suicide and prescribing any drug or device to perform or induce an abortion or otherwise performing or inducing an abortion are also prohibited.** Language similar to this was added to other health care regulatory boards' statutes by the General Assembly as an indication of the lawmakers' philosophical positions relative to these two very hot button policy issues.[5]

Applying the law

The Board received a complaint that a scantily clothed woman was part of a bachelor party celebration. The complaint arose when pictures of the party were circulated among the groom's family, and someone recognized the woman as the nurse who was caring for a hospitalized relative. The family contacted the Board to express their outrage. What is the extent of the Board's authority relative to this complaint? Does the Board have jurisdiction under the moral turpitude provision?

Whether the nurse's actions constitute moral turpitude is not a consideration in this hypothetical because the actions in question are not a criminal offense. In order to fall within the Board's purview there must be a criminal conviction, guilty plea, or judicial finding relative to a crime involving gross immorality or moral turpitude. While the nurse's actions might negatively affect the level of trust the family places in her, she does not risk licensure actions as result of her moonlighting job.

The Board's Disciplinary continued on page 14

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The Board's Disciplinary continued from page 13

> ***Applying the law***
>
> *Nurse Jane is struggling with a severe migraine headache and her usual medication is not working. In order to stay at work she decides to self-medicate using a controlled substance she received from a nurse colleague, Abigail, for whom the drug was originally prescribed. Abigail suggests that Jane take two pills rather than one and she does. A bystander who observed the nurses' activities reported what happened to the Board of Nursing. There were no claims that Jane's practice was impaired after she took the drugs.*
>
> *While no harm occurred and the nurses' actions were motivated by good intentions, both nurses are subject to disciplinary action by the Board. Abigail gave away a prescribed medication that was intended for her personal use not the use of her friend. Her actions constitute giving away a drug for other than a legal and legitimate therapeutic purpose. Jane self-administered a drug that was not prescribed for her. The Board will look at what happened in this situation and determine what sanction is warranted.*

How the Disciplinary Process Works

Having explored what can lead to Board sanctions, it is time to look now at how the process for taking action works. Section 4723.28 ORC provides the roadmap needed for this exploration. The process for taking action has several distinct steps that include complaints; investigation, consultation between Board of Nursing compliance unit staff members and the Board's Supervising Member for Disciplinary Matters; issuance of charges; hearing, settlement conference or consent agreement; and finally Board action. Each step will be considered in turn.

Complaints – As noted previously, the number of complaints the Board receives each year has steadily increased. Some speculate this is due in part to a general dissatisfaction or frustration patients and family members have with respect to their treatment within a health care facility. They express these concerns by filing a complaint with the Board of Nursing. The wonders of technology have simplified the process enabling complaint forms to be readily available through the Board's website. In addition to patients and family members, other sources for complaints include employers, co-workers, physicians or other members of the health care team, friends, and even soon-to-be ex-spouses. All complaints are confidential and may be filed anonymously, although the Board discourages anonymous complaints because of the follow-up challenges they present. The law further protects complainants by granting them immunity from civil damages arising from the complaint provided they acted in good faith. (Section 4723.28 (H) ORC).

Clearly the complaints received by the Board may or may not be legitimate and may or may not include allegations that constitute a violation of the Nurse Practice Act. For that reason, information as to whether someone is or is not the subject of a complaint is not available to the public. That information is confidential. The Board will neither confirm nor deny when asked about a situation affecting a specific licensee. Because some complaints may be filed for personal motives (revenge) it is important to protect a nurse's professional career from this potential sabotage.

The law requires the Board to investigate evidence that appears to show someone has violated the law regulating nursing practice or the rules of the Board. In light of this statutorily imposed obligation and due to the number of complaints the Board receives, it must prioritize its investigative efforts. Complaints in which the circumstances seem to indicate the most harm or potential for harm are considered top priority and receive immediate attention. Others further down the priority continuum may remain in the pending category for a longer period of time before the Board's investigators are able to complete their work.

The law does not set out any time frames or statute of limitations that dictates how long a complaint may remain unresolved. In fact, the complaint itself may be filed many years after the alleged conduct occurred. These delays, while not legally constrained, do affect case outcomes. The longer the time periods between the event, the complaint, and the investigation the more difficult it becomes to conduct an effective investigation and ultimately prove the allegations. For that reason, there is pressure on the Board to move as expeditiously as possible.

Just as in the criminal context, the state, or in this case the Board, has the burden of proof when moving forward. In other words, the state must prove its allegations, and the licensee is "innocent" until the Board proves otherwise. The burden of proof, however, is minimal in these types of administrative proceedings. A preponderance of the evidence is the standard the Board must meet, which means the Board's evidence has a slight edge over the evidence provided by the licensee.[6] This is not a particularly weighty burden and one that can easily be met if the licensee does not exercise his/her due process rights to the fullest.

Investigations – The Board utilizes the expertise of its enforcement agents to conduct investigations. While most of the investigators are registered nurses, they are also trained in investigative techniques. They are very good at what they do.

In addition to their skills, investigators have several tools at their disposal to help gather the evidence the Board needs to move forward. The law allows the Board to compel a licensee to submit to a mental or physical examination or both at the individual's expense if the Board reasonably believes the person may have an impairment that affects his/her ability to provide safe care. The Board may also issue subpoenas to compel witnesses to testify and require the production of various documents, including patient medical records when needed to prove the allegations.[7]

Nurses should not enter into discussions with investigators (no matter how innocuous it may seem) regarding an investigation to which they are a party without first consulting legal counsel. Similarly, if the nurse should receive a "license response form" from the Board he/she should work with legal counsel so as to respond appropriately. Responding is entirely voluntary. All of this is not to say nurses should be uncooperative with the Board. Rather they should be aware of the seriousness of the situation and careful not to inadvertently prove the case for the investigator. With those cautionary notes in mind, nurses can take steps to safeguard their license while still cooperating with the Board. Professional malpractice insurance frequently covers Board administrative proceedings.

Once the investigator has reviewed documents, spoken with the licensee and other witnesses, and generally completed the investigation, it is on to the next step to determine whether the evidence supports moving the case forward or whether it should be closed. The law allows the Board to forego action when the complaint involves a minor violation and the Board determines that the public can be adequately protected by the issuance of a notice or warning to the alleged offender. (Section 4723.061 ORC). Cases may also be closed for lack of sufficient evidence.

Consultation with the Supervising Member – The ultimate decision as to whether to impose sanctions rests not with the Board staff members but with the appointed members of the Board. In order to preserve that distinction, information obtained during the course of an investigation is presented to one of the Board members elected by his/her colleagues to serve as the Supervising Member for Disciplinary Matters. This individual has access to all investigative information in order to make the decisions as to whether the case should move into the next stage—official charges. The Supervising Member consults with Board staff regarding how an investigation is proceeding and is often privy to information regarding the challenges being faced during the course of an investigation. The Supervising Member may direct that the investigation be continued or may find the evidence insufficient to prove the allegation and therefore direct that the case be closed.[8] The Supervising Member may also recommend that the case be forwarded to one of the Board's alternative programs for follow-up.[9] Participation in these programs is confidential. If the Supervising Member determines that the case should move forward it then goes to the full Board for a determination as to how to proceed.

Charges and further action – adjudication processes

In order to preserve the integrity of the administrative process, the Supervising Member abstains from the full Board discussion and subsequent votes on the specific cases he/she has overseen. At its regularly scheduled meetings the Board members receive suggested Notices of Opportunity minus identifying information about the licensee. The Notice sets out in detail the charges being alleged and provides information as to what the licensee must do moving forward. The Board members review the substance of the Notice document, and upon a vote of a quorum, decide whether it should be issued. If the vote is to proceed, the information then enters the public domain and the formalized adjudicatory proceedings begin. It is at this point and not before that the licensee's name may find its way into the Board's publication *Momentum* and the general public gains access to the information contained in the Notice.

The Notice of Opportunity is sent to the licensee immediately following the Board's action thus satisfying its due process obligations. Whether the licensee takes advantage of the rights afforded to him/her is a personal decision; however, failure to do so means that the opportunity to offer evidence is lost forever. The Board will proceed even without a formal hearing to take the action it deems appropriate. In other words, ignoring the unwelcome news will not make it all go away!

The Board is authorized to conduct adjudicatory hearings either through the use of an attorney hearing examiner or by using a hearing committee made up of at least three Board members. Hearings may also be conducted by the full Board although this is a rare occurrence. Hearings are generally open to the public and modified rules of evidence apply. The Board is represented by its legal counsel, an assistant attorney general from the State of Ohio. A court reporter is on hand to record the proceedings and provide a transcript of the entire process to the Board and the licensee (respondent). Each side may call witnesses, ask questions, and submit documentary evidence as exhibits. Within four months after the hearing is completed, the hearing examiner or the Board hearing committee submits a written report that includes its findings of fact, conclusions of law and recommendations regarding the level of sanction that is merited by the evidence. The parties have ten days to file objections to this report. All of this material, including the hearing transcript and any objections filed within the time frame, is then forwarded to the full Board (assuming the full Board did not conduct the hearing) for review.

Board members meet in executive session (where Board staff and the public are not in attendance) during their regular meetings to deliberate and decide whether to uphold the recommendations of the hearing examiner or Board committee or substitute their own sanction. Several factors known as aggravating or mitigating circumstances can be considered as part of the deliberations.

Aggravating factors such as prior disciplinary action, dishonest or selfish motives, and lack of truthfulness, refusal to acknowledge the wrongful nature of the conduct or the vulnerability of the victim could lead to more severe action. Conversely, absence of a prior disciplinary record, absence of a dishonest or selfish motive, free and full disclosure to the Board, a physical or mental impairment, interim rehabilitation or remedial measures, and the length of time since the incident or conduct occurred are all factors that could mitigate or lessen the sanction imposed. Once a decision is made, it becomes official through a vote of a quorum of Board members in a public session.

Needless to say the hearing process can be grueling and its trappings intimidating at best. Surprisingly, nurses, more often than one might imagine, appear at their hearings without benefit of legal counsel. While hearing examiners do what they can to ease the nurse through the process, the nurse is at a significant disadvantage that cannot be rectified later.

> ***What next?*** – *You've just received a certified letter from the Board of Nursing and inside is a Notice of Opportunity. You knew you were being investigated by the Board because you spoke to one of its nice enforcement agents several months ago. This document though is not exactly what you anticipated. It is very formal and contains a series of paragraphs detailing the date and time in which your actions in caring for several patients are alleged to have violated the law regulating nursing practice and rules of the Board. It is a long letter and at the end it says you may request a hearing in the matter to present your position, arguments or contentions either by appearing at the hearing or in writing. You may be represented by legal counsel. If you want to take advantage of this opportunity you must notify the Board in writing within thirty (30) days of the* ***mailing*** *of the notice. If you don't request a hearing, the factual and legal allegations set forth in the notice will be considered by the Board and your license to practice nursing could be permanently revoked, suspended… . Now you are really scared. The notion, "Maybe if I just ignore the notice it will all go away" flits briefly through your mind. But that really doesn't seem like such a good idea. What are your options?*
>
> *First seek legal counsel from someone with experience in administrative law. Ask the attorney to make sure your options are preserved by requesting a hearing within the specified time frame. Then explore with your attorney how best to proceed. Is a hearing the only option? What else might be done to get the matter resolved? Is there room for discussions regarding possible outcomes that would preserve your license?*

The Board's Disciplinary continued on page 15

The Board's Disciplinary continued from page 14

An adjudicatory hearing is not the only option available for resolving a dispute with the Board. In fact, in lieu of a hearing, the Board may enter into what is called a Consent Agreement to resolve the allegations at issue. These agreements are essentially a negotiated document that includes stipulations, admissions, and understandings voluntarily agreed to by the licensee. The agreement sets out the sanctions to be imposed and the consequences facing the licensee for failure to comply with the terms of the agreement.

Once the parties settle on the terms, the proposed language is presented to Board members for review and consideration at one of their meetings. While the terms of the Consent Agreement may represent an acceptable resolution for the parties, the agreement is valid and enforceable only if ratified by a vote of a quorum of the Board. It is not unusual for individual Board members to express concerns or oppose specific agreements because they believe the sanctions are not appropriate in light of the facts of the case. If enough members refuse to ratify the agreement, the case remains unresolved and returns to the Compliance unit for further attention. Sanctions imposed via a ratified Consent Agreement are considered disciplinary action and must be reported as such by the nurse to employers and other regulatory boards.

Board of Nursing decisions other than those made through Consent Agreements, may be appealed by the licensee to the Franklin County Court of Common Pleas. The grounds for appeal are limited and the process is not intended as a way to re-hear the facts of the case. In other words, a nurse who has failed to exercise his/her due process rights during the administrative proceedings cannot use the court as a substitute venue.

Board sanctions are public information and are published in *Momentum*, on the Board's website and submitted as required by law to the National Practitioner and Healthcare Integrity and Protection Data Banks. The fact that a nurse has been disciplined by the Board appears on the license verification portion of the Board's website as well. The information does not disappear over time. Rather, it follows the nurse throughout his/her entire professional life. Publication is not intended to embarrass the nurse but to protect the public from unsafe practitioners.

Other considerations

The Board may ask an individual to consider voluntary surrender of his/her license to practice. Under certain circumstances a voluntary retirement may be proposed. While this may appear to be a benign choice, the reality is the individual cannot engage in practice and should he/she seek to rescind the surrender, the Board will initiate disciplinary proceedings. If the individual attempts to seek licensure in another state, the Ohio Board will notify that state of the individual's licensure status. All voluntary surrenders or retirements are valid only if ratified by a vote of the Board members.

As noted above, a nurse who is convicted of a felony or in certain circumstances a misdemeanor could also face licensure action by the Board of Nursing. Some may believe this constitutes double jeopardy – in essence punishing the individual twice for the same offense. The actions of the Board are not intended to "punish" the nurse but instead are undertaken to protect the public. The difference is a subtle but important distinction.

There are additional nuances with respect to criminal convictions. If a criminal action is brought against a licensee and the trial court dismisses the action for reasons other than on the merits,[10] the Board must conduct an adjudication to determine whether the individual committed the act in question. If the Board finds through its adjudication that the individual committed the offense, it may proceed as if the trial court had issued a conviction. It is important to note the burden of proof for the Board is less strenuous than that of the trial court in these circumstances, thereby increasing the likelihood the Board will find the licensee committed the act in question. The Board's finding is not considered a conviction for criminal purposes, but it is sufficient for the imposition of licensure sanctions.

If a conviction rendered by a court is overturned by an appellate court on the merits of a case, and the Board has taken action based on the original conviction, the Board must rescind its action. The rescission is required, however, only if the appeal was based on the merits of the case and not if founded on procedural matters.

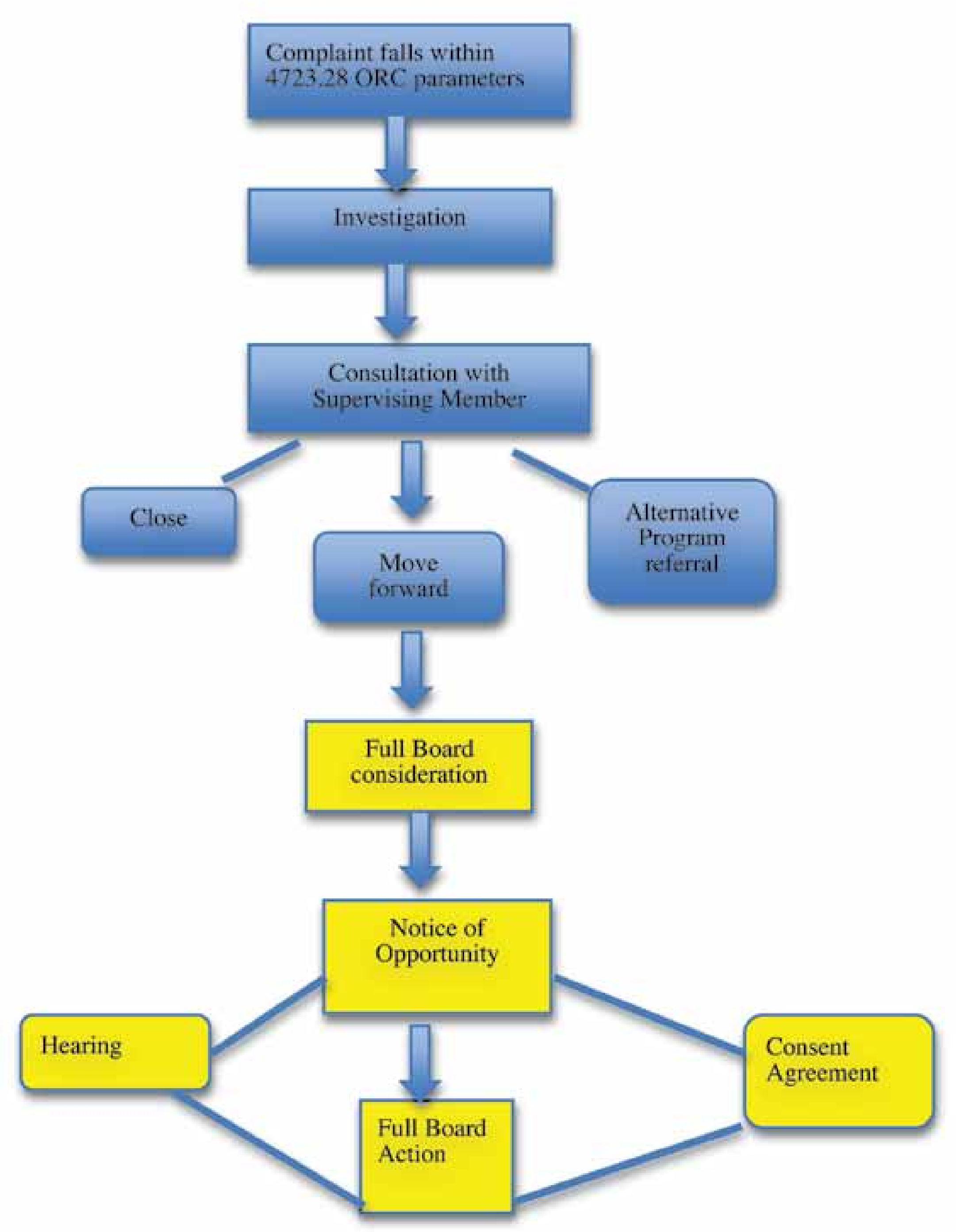
Finally, if the Board takes action on the basis of a criminal conviction or judicial finding and the records of that proceeding are sealed, the Board's action or any sanction imposed are not affected by the sealing of the records. Further the Board is not required to seal or modify its records simply because the court did so.

Conclusion

Nurses who face potential action by the Board of Nursing should be aware of their rights and obligations under the law. That is not to say disciplinary action and licensure sanctions are not warranted in certain situations. It is important, however, for nurses to be aware of the provisions in law that set out practice expectations and the procedural protections available to them. The law and the administrative processes guaranteed by it work best when the governed parties are both aware of the provisions and confident that their interests are fairly served.

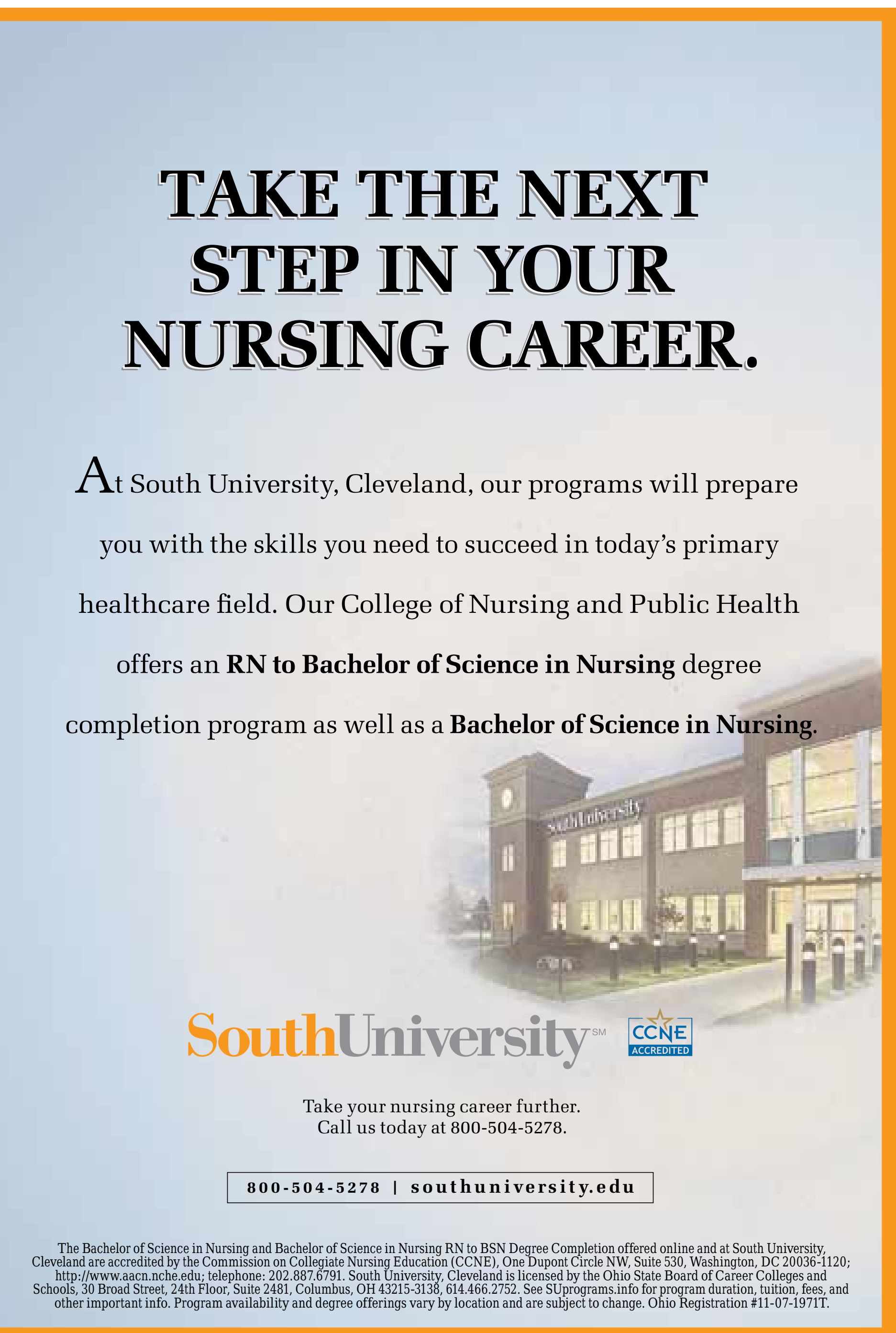
The opportunity to practice nursing carries with it an obligation to act in accordance with laws, regulations and other professional ethical considerations. In order to warrant the public trust, nurses subject themselves to the jurisdiction of regulatory boards and all the accompanying obligations such regulatory oversight entails. Regulatory boards constantly strive to meet their public protection mission while balancing the legitimate rights of their licensees.

This balancing act can be a delicate one. On occasion the public may view a regulatory board simply as a means for the proverbial "fox to guard the henhouse." In other words, the professionals sitting on the boards are there solely to protect their colleagues and not to serve the public's interest. For that reason most states, including Ohio, have expressly reserved seats on these boards for consumer members who have no vested interest in the profession being regulated. The Ohio Board of Nursing takes its compliance obligations seriously by conscientiously exercising its responsibilities to protect the health of the public through the effective regulation of nursing care. Ultimately everyone benefits from this consistent oversight—the public by being assured that the nurses providing care are competent to do so, and nurses by being confident of the competency of their colleagues—an important factor in the fast-paced complex world of today's health care system.



1. The Board of Nursing is made up of 13 individuals – 8 registered nurses (one of whom must be an advanced practice nurse); 4 licensed practical nurses; and one consumer member. Board members are appointed by the governor to serve a four (4) year term with one additional term allowed if re-appointed. Board meetings are public and are held six times per year at the Board office in Columbus.
2. The Board's Annual Reports are available at its website www.nursing.ohio.gov. The reports cover a fiscal year and date from July 1-June 30 of the respective year.
3. The number of complaints far exceeds actions taken. Some of the reasons for that discrepancy will be discussed later in this study.
4. When the Board has clear and convincing evidence that continued practice presents a danger of immediate and serious harm to the public, a summary suspension may be imposed without a hearing. The Board must provide an opportunity for a hearing within 15 days but no earlier than 7 days after the hearing request is received. The suspension remains in place, unless it is reversed by the Board, until a final adjudication order is issued (within 90 days after the adjudicatory hearing). (Section 4723.281 ORC).
5. Additional provisions in Section 4723.28 ORC specifically address issues pertaining to advanced practice nurses such as waiver of deductibles and copayments, failure to meet quality assurance standards or failure to practice in accordance with standard care arrangements required for APN practice.
6. The clear and convincing evidentiary standard required for summary suspension in Ohio and in some states for all administrative proceedings means the thing to be proved is highly probable or reasonably certain. In criminal proceedings the standard is beyond a reasonable doubt, the highest evidentiary burden. (Black's Law Dictionary, 7th Edition).
7. Patient identifiers in these records are kept confidential both during the investigation and in any subsequent proceedings. Information received during an investigation is confidential and not subject to discovery; however, the information may be disclosed to law enforcement and governmental entities investigating the licensee.
8. Investigative files are maintained as is information regarding the complaints received against a particular licensee. If additional information is obtained at a later time, the case may be re-opened.
9. The Board has been authorized by the General Assembly to conduct two alternative to disciple programs—the alternative program for chemical dependency and the practice intervention and improvement program. If an individual is referred to one of these programs, they must enter into a participatory agreement and agree to certain specific requirements. If they meet the criteria established for participation in one of these programs and successfully complete it, no disciplinary action will be taken. Failure to satisfy program requirements, however, is grounds in and of itself for disciplinary action.
10. A case may be dismissed for procedural reasons without ever deciding whether the accused is guilty or not guilty of the criminal offense that formed the basis for the accusation (the merits).

For the test part of this independent study, please refer to CE4Nurses.org and click on Ohio Nurse Independent Studies.



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