Florida Nurses Association
93rd Convention

September 26-29, 2007

SUMMARY OF ACTIONS

Intellect, Intuition and Innovation

Hallmarks of Nursing Excellence

Hilton Daytona Beach Oceanfront Resort,

Daytona Beach, FL

FLORIDA NURSES ASSOCIATION

4th Biennial
93rd FNA Convention
September 26-29, 2007
Hilton Daytona Beach Oceanwalk Resort
Daytona Beach, Florida

SUMMARY OF ACTIONS

Nurses and nursing students alike heard the inspiring keynote address of Leah Kinnaird on opening day of the 4th biennial and 93rd Convention of the Florida Nurses Association (FNA). Through out the meeting, including the pre convention session participants were given the opportunity to attend continuing education offerings on timely issues in addition topics meeting the mandatory continuing education requirements. Delegates to the House of Delegates participated in spirited debate and adopted position statements on critical issues affecting the profession. Through efforts of the Florida Nurses Foundation and a special fundraiser by LERC, funds were raised to assist the Florida Nurses Foundation Nurses In Need Program. In addition, the House of Delegates passed the first FNA dues increase since 1992. The election results of the 2007 – 2009 FNA Board of Directors were announced with formal installation at the close of session.

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2005 – 2007

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Florida Nurses Association

Goals for 2007 - 2009

1. Increase FNA membership by focusing on retention strategies.

2. Expand the public understanding of the varied and significant roles of Registered Nurses in the State of Florida and contributions to healthcare and society by marketing the communication plan.

3. Continue to serve as a major resource for professional career development of Registered Nurses in the State of Florida through the provision of educational programs and experiences.

4. Continue to serve as the primary resource in legislative and professional practice initiatives for Registered Nurses in the State of Florida.

5. Seek partnerships and coalitions with consumer and professional organizations to advance the profession of nursing.

6. Advance statewide awareness of programs that recognize nursing excellence.

7. Explore fundraising mechanisms to increase non-dues revenue.

Adopted by the House of Delegates
9/29/2007

Increasing Nurses' Awareness of Public Cord Blood Donation.

The general public, including registered nurses, are unaware of opportunities and procedures available for cord blood donation and storage. It is important that all health care providers be educated about the National Marrow Donor Program collection of umbilical cord blood for public use.

BACKGROUND:
Expansion of the National Marrow Program and the National Cord Blood Inventory Programs are necessary to increase access to live-saving medical treatments. Private storage of human cord blood is very costly and often does not meet the needs of individual families unless they have specific high risk factors. The American Academy of Pediatrics does not recommend private storing of cord blood unless the family has a current need or very high potential risk (http://www.nationalcordbloodprogram.org/donation/public_vs_private_donation.html). A national registry, with international search capability, improves the likelihood of finding a donor match (http://www.corduse.com/faq.htm). Continued peer-reviewed study of umbilical cord blood is also important to the advancement of medical treatments.

In 2005, the U.S. Congress passed Public Law 109-129, the Stem Cell Therapeutic and Research Act of 2005, that provides for the collection and maintenance of human cord and blood stem cells for the treatment of patients and research (http://www.nationalcordbloodprogram.org/cord%20blood%20public%20law%20109-129%20(2).pdf). The law stipulates safe and ethical guidelines for the U.S. Department of Health and Human Services (USDHHS) to enter into agreements with cord blood storage and transplantation centers "for the purpose of increasing the number of transplants for recipients suitably matched to biologically unrelated donors of bone marrow and cord blood." The Act provides funding for the program through 2010, including educational activities which include informing the general public, providing information to pregnant women who are willing to donate cord blood units, and training individuals in requesting pregnant women to serve as cord blood donors.

In 2006, the USDHHS Health Resources and Services Administration (HRSA) awarded funds totaling $12 million to the first group of umbilical cord blood banks to begin collections for the National Cord Blood Inventory (NCBI). The NCBI will collect and maintain high-quality cord blood units and make them available for transplantation through the newly created C.W. Bill Young Cell Transplantation Program http://newsroom.hrsa.gov/releases/2006/blood-units.htm. Qualified cord blood banks must contract for a period of at least 10 years. The contracted blood bank is required to include a "system for encouraging donation by genetically diverse groups of donors" and a "system to confidentially maintain linkage between a cord blood unit and a maternal donor."

To date the number of Florida hospitals participating in collecting cord blood for the National Bone Marrow Program is limited to nine out of 256 hospitals. Only three agencies in Florida collect umbilical cord blood for the National Bone Marrow Program: Cryobanks, LifeSouth, and Cord Blood Banks. These are all located in central Florida and this limited access to the National Marrow Program and the National Cord Blood Inventory is a barrier to health care for

the citizens of Florida. Ready access to diversified ethnic cord blood is needed to improve the success of transplantation and it is important to expand access to a national registry.

STATEMENT OF POSTION: The Florida Nurses Association supports the National Marrow Donor Program collection of umbilical cord blood for public use and recognizes the need for increased education for health care providers, nursing students and pregnant women about the availability of pubic cord blood donation and the National Marrow Donor program.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. Support legislation to increase funding, education and public participation in the National Marrow Donor Program.
2. Support professional nurses' leadership roles in educating nurses, nursing students and other health care providers about the benefits of cord blood donation.
3. Support efforts to include education on public umbilical cord donation as part of prenatal education.
4. Request obstetric and gynecologic health care practitioners to include information on donating cord blood in prenatal visits.
5. Support education for all nurses and doctors in labor and delivery regarding the proper procedures for collecting cord blood.
6. Support efforts to increase the diversity pool of cord blood donors.

REFERENCES:
Cord USE: A Public Donation Cord Blood Bank http://www.corduse.com/
National Cord Blood Program http://nationalcordbloodprogram.org

PAST ANA HOUSE ACTIONS:
None

PAST FNA HOUSE ACTIONS:
None

Adopted by the House of Delegates
Friday, September 28, 2007

Workforce Advocacy for Safe Patient Handling: Beyond Legislation

Statistics and research are legion; nurses and other healthcare workers are at high risk for musculoskeletal disorders (MSD). Frontline caregivers are routinely exposed to high risk patient handling activities such as manual lifting, transfers and repositioning of patients. The physical burden of these activities exceeds the capacity of most caregivers. According to the US Department of Labor (2006), nurses (RNs & LPNs) as well as nursing aides have one of the highest job-related injury rates of any occupational category. In this population, work-related strains and sprains particularly of the back, was ranked third highest; only construction workers and “trade/transportation and utilities” showed higher rates. Moreover, the most common interventions to decrease risk (increased attention/education, body mechanics and other low tech ergonomic strategies) have for the most part been unsuccessful (Nelson, 2006).

BACKGROUND:
Stetler and colleagues (2003) clearly summarized the available research-based observations related to the prevention of MSDs in nurses, and identified several conclusions. First, simple solutions don't work; multiple simultaneous strategies are needed. Programs with sustained effects included at least two of the following four factors: risk reduction such as conditioning/screening of patient handlers, "engineering" controls such as lift teams and/or ceiling lifts, "administrative controls" such as mandatory no-lift policies, and multidisciplinary training/education programs. It is stressed that educational programs alone do not work. Stetler *et al*'s conclusions are confirmed by an international integrative literature review (Hignett, 2003). Results emphasized that single strategies, particularly education alone, are ineffective. Notably, there have been a number of studies that support the efficacy of patient handling/lift equipment in concert with no lift policies (Collins, Wolf, Bell, & Evanoff, 2004; Nelson, Owen, *et al*, 2003; Nelson *et al*, 2006). Likewise, patient handling/lift teams have contributed to lowering injury rates (Guthrie *et al*, 2004). Moreover, data support that return on investment is not only possible, but generally recouped in less than three years. Not only is the incidence of injuries reduced and quality of care increased, but workers' compensation costs and lost work days decrease resulting in significant savings (Collins *et al*, 2004; Nelson *et al*, 2006; Tiesman, Nelson, Charney, Siddharthan, & Fragala, 2003).

The frequency and risk factors for MSD correlate with the individual healthcare setting. While optimum conditions for safe patient transfer may not always be possible there are a number of interventions that when implemented make an impact on reducing MSD. Most research agrees that not one single intervention alone is as effective as a multiple intervention strategies approach.

Definitions:
Ergonomics is defined as the science of fitting the task to the worker (Waters, Collins, Galinsky, & Caruso, 2006).

Lift is defined by Stetler *et al* (2003) as moving entire weight of patient from one surface to another (e.g., from bed to chair or floor to bed). The term "lift" describes only one component of the broader concept of "patient handling".

Musculoskeletal Disorder (MSD) is defined as "an injury or disorder of the muscles, nerves, tendons, joints, cartilage, or spinal discs. These disorders are related to events such as bodily reaction, overexertion, and repetitive motion and do not include injuries caused by slips, trips, falls, motor vehicle accidents, or similar accidents" (U.S. Department of Labor).

Patient handling includes actual lifting, transfer from one surface to another, as well as repositioning in the chair or bed.

Transfer is defined as assisting a patient from one position to a different position (e.g., from bed to chair or commode to bed). Flat transfer is assisting a patient from one flat surface to another (e.g., from bed to stretcher). Reposition involves adjusting or assisting a patient to a new position on the same surface (e.g., to boost up in chair or bed).

STATEMENT OF POSITION:
The Florida Nurses Association supports both "top down" (macro, policy and support) and "bottom up" (micro, operational) strategies. The workforce at risk needs to systematically implement evidence-based strategies that promise to reduce the incidence of MSDs. Those in a position to garner resources and influence policy (healthcare administrators/trustees and

nursing management) must facilitate the adoption and maintenance of these strategies. In light of the current nursing shortage, recruitment and retention challenges, an aging workforce, and the epidemic of obesity, quality patient care depends on it. The approaches are varied and fall into three general categories: education of the workforce to decrease MSD, modification in the work environment, and changes in organizational policy.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. Create two information sheets describing actions to minimize the occurrence of musculoskeletal disorders: one for top down implementation and another for bottom up grassroots influence. The information sheets will include the strategies as stated below and any additional recommendations obtained from workforce nurses.
2. Disseminate the information sheets broadly by providing copies to: FONE, FADONA, FHA, FHCA, FAHSA, FCN, FCNEA, and FACN. The information sheets will be available online at FNA website and published in *The Florida Nurse.*

Strategies for Safe Patient Handling: Beyond Legislation:

- Education
  - Form a committee to assess elimination of risk factors and define type of handling task: number of handlers, level of patient dependence, patient's weight and equipment required (Stetler *et al*, 2003; Hignett, 2003)
  - Committee should include management, caregivers, purchasing, risk management, occupational (deCosto *et al*, 2006)
  - Training and education of staff on no lift policy (Stetler *et al*, 2003)
  - Best practice to address lifting and repositioning aids (Collins et al., 2004)
  - Demonstration and hands on comprehension of lift equipment (Collins *et al*, 2004)
  - Report injuries as handling injuries are cumulative in nature and underreported (Nelson *et al*, 2006)
  - Physical conditioning programs (Li *et al*, 2007)
- Work Environment
  - Patient assessment by staff on type of handling task/ perceived need to include number of handlers, level of patient dependence and patient's weight and equipment to use (Stetler *et al*, 2003; Li *et al*, 2007; Myers, Kriebel, Karasek, Punnett, & Wegman, 2007)
  - Engineering controls, for example, use of a "lift" team or structural device (Stetler *et al,* 2003)
  - Physical therapy to establish safe patient handling guide (Stetler *et al,* 2003)
  - Use card system that identifies safe patient handling for every level of patient ambulation as facilitates correct communication (Hignett, 2001).
  - Lift equipment conveniently located, easy to use, and easy to clean or equipment will not be used (Waters *et al,* 2006; Li *et al,* 2007)
  - Implement transfer equipment in building design, furniture, and lifts (Hignett, 2001; Waters *et al,* 2006)
  - Use of friction reducing sheets (Collins *et al,* 2004; Li *et al,* 2007)
- Organization
  - Target problem solving (Hignett, 2001; Nelson *et al,* 2006)
  - Implement a no lift policy (Stetler *et al,* 2003)
  - Written zero lift policy (Collins *et al,* 2004; deCosta *et al,* 2006; Li *et al,* 2007)
  - Work with schools of nursing on training evidenced based safe patient handling (Nelson *et al,* 2006; Waters *et al,* 2006)

- Influence ergonomic strategy of manual handling as part of the organizational culture for health and safety (Hignett, 2001)
- Use of physical therapist for safe patient handling guide (Stetler *et al,* 2003)

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PAST FNA HOUSE ACTIONS:
Nursing Workforce Safety: No Lift Environments and Safe Patient Handling and Movement Initiatives, 2003
Health Care Ergonomics for Nurses, 1995

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Friday, September 28, 2007

Preparation for Disaster Response

Recent events, both natural and manmade, have caused our nation to focus on the need to be prepared to deal with any disaster. Health Care Workers are considered front line responders in dealing with those injured, or in protecting and/or treating those exposed or considered most vulnerable. They must be educated in the proper response techniques.

BACKGROUND:
Nurses have always been involved in planning and providing care in all settings, primary, secondary and tertiary. Identifying the nurses' role in preparing to support our community in the event of a disaster is another opportunity for nurses to be proactive in giving their input into a community preparedness plan. In this way, we are prepared to provide the care that those affected will need, while, at the same time, learning how to protect ourselves from exposure.

It is vital for health care organizations and health care workers to prepare appropriately to respond to disasters. A disaster event, such as an influenza pandemic, is projected to have a global impact on morbidity and mortality, thus requiring a sustained, large scale response from the health care community (OSHA, 2007). With such an event, a substantial percentage of the population will require some form of medical care, which will quickly overwhelm the health care system, and the physicians and nurses working in it, locally, regionally, and nationally (Trossman, 2007). Collaboration with state and federal partners is vital to ensure that healthcare workers are adequately educated and protected so that they can respond to a disaster.

Definitions:
City Ready Initiative – A CDC program providing direct assistance to specific densely populated areas to build a response capacity needed for the prophylaxis of 100% of the population within 48 hours of an event. The Medical Reserve Corp is part of this initiative.

Disaster Community Assessment Team is composed of health care volunteers that provide information on the health needs of their community so that interventions can be initiated through the Points of Distribution (PODS)

STATEMENT OF POSITION:
The Florida Nurses Association advocates nurses' involvement in community disaster preparedness plans.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. Promote education on Disaster Preparedness to insure that its members have information on resources for All Hazards Training so that they can teach themselves, their families and their clients how to become prepared.
2. Educate nurses about resources available to promote their safety and prevent injuries as they provide disaster services in hospitals and community shelters.
3. Advocate volunteering with local Public Health Departments in times of need to assist with mass antibiotic distribution, shelter management, Flu campaigns, etc.
4. Inform nurses about the Medical Reserve Corp, including its purpose and activities and how to sign up for a local unit.
5. Encourage nurses to participate in their local Disaster Community Health Assessment Team (DCHAT) to assess health and medical needs post event.

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PAST ANA HOUSE ACTIONS:
None

PAST FNA HOUSE ACTIONS:
None

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Effects of Physical and Emotional Fatigue on Nurses in the Workplace

For nurses, conditions of work cause physical and emotional stress and fatigue due to intense workload, long shifts, interpersonal relationships and exposure to traumatic events.

BACKGROUND:

Recent studies show the effects of both physical fatigue and emotional stress on nurses and their practice (Agency for Healthcare Research and Quality, 2003; Tabone, 2004; Winwood & Lushington, 2006). Nurses must become aware of the impact of the impact of these factors on their concentration and decision making abilities as they care for their patients. As nurses become more aware of the impact of fatigue, both physical and emotional, encountered in daily practice, nurses can take the necessary steps to cope with these stressors.

A 2003 Institute of Medicine report identified research findings on overtime practices in safety sensitive industries, such as nursing and aviation, indicate that long work hours without adequate and quality rest time is associated with impaired performance and human errors. Shift work and sustained operations are common to nursing care and result in inadequate and poor quality rest. The National Sleep Foundation has documented that a deficit of sleep is associated with decreased alertness, problems with concentration and unsafe decision making.

Nurses experience occupational stressors including workload issues, interpersonal relationship issues, and death and dying/loss concerns. Compassion fatigue is an emotional response that health care providers may experience to traumatic events that befall their patients (Schwam, 1998).

STATEMENT OF POSITION:
The Florida Nurses Association believes that it is essential that nurses be educated about the physiological and psychological effects of fatigue and effective ways to reduce common stressors.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. Advocate for continued research and education regarding the effects of physical and emotional fatigue in the workplace on nurses' well-being and nursing practice.
2. Provide educational resources to nurses regarding sources of stress reduction and relaxation techniques to help relieve the physical and emotional stress.
3. Advocate to health care employers and the Florida Organization of Nurse Executives to establish programs to assist nurses with stress related workplace issues.

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PAST ANA HOUSE ACTIONS:
None

PAST FNA HOUSE ACTIONS:
None

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Medication Administration by Unlicensed Assistive Personnel

Elders and people with disabilities who live in community long term care settings take numerous medications to manage chronic health problems. Many of the medications pose significant risk for adverse reactions and drug interactions. Unlicensed, under trained, assistive personnel comprise the majority of the direct care staff in this setting.

BACKGROUND:

Assisted living (ALF) and congregate living offers a more home-like environment than traditional forms of long term care such as nursing homes. Both rely on a social model which is a less expensive long term care alternative. Unlicensed assistive personnel (UAP) assist residents in these facilities with health maintenance activities including medication administration. This is a concern because there is rarely 24 hour on-site coverage by licensed nurses. According to the State of Florida regulations, UAP are required to take a 4-hour course prior to providing patient care. However, this training varies between facilities and is often not competency based. Competency based training requires the learner to demonstrate documented competency in the skills trained. Current training relies on a nurse to "certify" the learner is competent; however, since training certification is not standardized across Florida different nurses can "certify" varying competencies.

ALF and congregate care residents take about the same number of medications as nursing home residents and include high risk medications such as psychotropics, anticoagulants, and cardiovascular agents (Armstrong, Rhoads, & Meiling, 2001; Clark, 2001). Most residents take medications to manage chronic illnesses, and medication regimens may be complicated and subject to change over time (Armstrong, et al, 2001). Since 2000 there has been a 200% increase in the number of states that permit UAP to either administer or assist with self-medication in long term care (Reinhard, Young, Kane, Quinn, 2006).

Florida only permits UAP, in ALF, to "assist" with self-administration of medications but there seems to be a blurring of the definition of "assistance". However, in day programs for the developmentally disabled, UAP are permitted (F.S. 393.506) to *administer* medications.

There is a lack of consistency in the delivery and monitoring of medication administration in the ALF and congregate care settings. Neither the resident nor the UAP have the professional background and training to manage and monitor drug interactions, medication administration guidelines, and identification of adverse drug events. In addition, there currently is no guideline for literacy screening of UAP who assist with medication delivery, so Florida consumers are not protected from medication administration by unlicensed personnel who cannot safely distinguish one medication from another.

Community based long term care is here to stay. It has proven to be a cost effective way for elders, persons with developmental disabilities, and mentally incapacitated individuals to maintain some level of independence. It is important to protect this vulnerable population group from harm.

STATEMENT OF POSITION:
This clinical issue significantly impacts the practice of nurses and the quality of care residents receive in ALF and congregate care settings. The Florida Nurses Association endorses a cooperative effort with the Florida Board of Nursing to develop statewide competency standards for UAP who work in the ALF and congregate care settings. Florida needs to support and mandate at least general supervision of UAP by a licensed nurse when UAP perform duties that have been reserved for licensed professionals. In addition, both consumers and health care providers need clarification of the Florida Nurse Practice Act concerning accountability of the nurse who delegates direct patient care to the UAP. The position is consonant with the international patient safety movement.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. That the FNA form a task force to work in collaboration with the Florida Board of Nursing to investigate the need for consistent regulation of unlicensed assistive personnel as relates to medication administration including assistance with “self administration”.

2. The task force will then report their findings to the 2009 House of Delegates.

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PAST FNA HOUSE ACTIONS:

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Medication Administration by Unlicensed Assistive Personnel, 1980

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Eradication of Horizontal Violence and Bullying in Nursing

Horizontal violence and bullying among nurses has been well documented in nursing literature. Negative interactions between nurse colleagues can result in poor working relationships, negative outcomes such as decreased retention of staff, and in the clinical arena, compromised patient care (Longo & Sherman, 2006).

BACKGROUND:

Horizontal violence is defined as harmful behavior via attitudes, actions, words and other behavior that is directed toward us by colleagues (Conti-O’Hare & O’Hare, 2006). Bullying in the workplace is described as repeated, health-harming mistreatment of one of more persons by one of more perpetrators that takes the form of verbal abuse, threatening, humiliating or offensive behavior or actions (Coombs, 2007). These phenomena alone or together can have devastating effects on the target of such behaviors and can negatively affect the work environment for all involved. On a personal level horizontal violence and bully can result in sleep disorders, poor self-esteem, hypertension, eating disorders, nervous conditions, low morale, disconnectedness, depression, impaired personal relationships, removal of self from workplace, and suicide.

It is believed that horizontal violence arises as an expression of an oppressed group behavior evolving from feelings of low self-esteem and lack of respect from others. Nursing has been described as an oppressed group because the profession is primarily female and has existed under a historical patriarchal system that is headed by male physicians, administrators and marginalized nurse managers (Longo & Sherman, 2006). They feel a lack of control over their work environments and rather than venting their frustrations on the source of their frustration, they create conflict within their own group with horizontal violence among colleagues.

Horizontal violence can be costly to institutions and organizations leading to job dissatisfaction, burnout and physical stress. Research indicates that in environments where this behavior is allowed to continue, many nurses will leave the environment and perhaps even the profession. In some instances, for example, when student clinical groups rotate through a unit, it may even affect an institution's ability to recruit new nurses (Longo & Sherman, 2006).

There is an abundance of literature related to the horizontal violence leveled against new graduates. The phenomenon of "nurses eating their young" is widely known and well-documented. This behavior is extremely detrimental to the future of the profession as well as to the quality care of our citizens (McKenna *et al*, 2003).

STATEMENT OF POSITION:
The Florida Nurses Association recognizes the devastating impact of horizontal violence and bullying in nursing environments and believes there is imperative that institutions and organizations engage in ongoing, proactive intervention to eradicate these detrimental behaviors from all nursing environments. We believe that this negative behavior not only damages individuals, organizations and institutions but also the entire profession by creating an environment of negativity as well as a lack of unity, cooperation and collaboration among nursing professionals.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:

1. Provide education regarding horizontal violence and bullying via FNA publications, continuing education programs, and other media to increase awareness of the devastating effects of horizontal violence and bullying on nursing environments.
2. Develop resources to assist individual nurses in managing horizontal violence and or bullying in their environments.
3. Utilizing current research, develop tools, resources and education programs for institutions and professional nursing groups to utilize with the goal of eliminating horizontal violence and/or bullying in their respective environments.
4. Encourage the inclusion of content on horizontal violence including strategies for prevention and intervention in incidences of horizontal violence and bullying in the workplace in nursing curriculums in all Florida nursing programs.

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PAST ANA HOUSE ACTIONS:
None

PAST FNA HOUSE ACTIONS:
None

PAST NATIONAL STUDENT NURSES ASSOCIATION ACTIONS:
Resolution in support of professional workplace culture and decreasing horizontal violence, 2006. (http://www.nsna.org/pubs/pdf/resolution%202006.pdf)

Adopted by the House of Delegates
Saturday, September 29, 2007

Influenza Immunizations

Nurses as well as other healthcare workers are at high risk of acquiring and transmitting Influenza viruses to their patients, each other and their families. Despite efforts to increase healthcare workers acceptance of annual influenza vaccinations the rate remains between 36 to 40%. Increased compliance with taking an annual "flu" shot is a key prevention and patient safety strategy in which nurses can play a major role.

BACKGROUND:
The following represents relevant facts:

- Influenza caused by a "seasonal" strain causes significant morbidity and mortality in the United States.
    - 20% of population affected each year
    - 36,000 deaths/year in the U.S.
    - 6th leading cause of death in adults
    - >260,000 excess hospitalizations/year
- Influenza infected healthcare workers (HCWs) transmit influenza to their patients.
    - Serologic studies indicate that up to 25% of HCWs have evidence of influenza infection each season.
    - Influenza can be transmitted while asymptomatic – causing potential for transmission to patients, each other and their families even before symptoms begin.
    - HCW influenza immunization rates are less than 40%.
    - HCWs don't get influenza vaccine because:
        - They believe they are not at risk
        - Do not understand the risk they represent to their patients
        - Inappropriate fear of vaccine side effects (e.g., *it causes the flu*)
        - Lack of knowledge about vaccine efficacy
        - Fear of needles
- Healthcare acquired influenza is a significant patient safety and quality of care problem.
    - Patients most vulnerable to influenza include:

    - Neonates, infants and children < 2 years of age
    - Elderly patients
    - Immunocompromised patients – acute and chronic
    - Critically ill patients
  - Impact of healthcare associated influenza infection transmission
    - Morbidity - Severe illness
    - Death
    - Increased hospital length of stay (LOS) and costs
  - Healthcare associated outbreaks/epidemics of influenza which can occur with a seasonal flu strain may cause disruption of essential services of a hospital during a season when patient census and HCW absenteeism are high.
- Impending influenza pandemic
  - History of pandemics indicates another can occur at anytime
  - Current concerns are with H5N1 a.k.a. “bird” or “avian” flu which if it sustains person to person transmission it could start mutating and could include inner action with whatever the current seasonal strain is at the time.
  - A recently developed vaccine with reportedly limited protection against H5N1 is available in small quantities and is controlled for distribution by the Centers for Disease Control (CDC).
  - Unpublished data indicates that a seasonal vaccine may provide limited protection against a pandemic strain as a result of the previously noted mutating.
- The cornerstone of efforts to prevent healthcare acquired influenza is HCW influenza immunization.
  - CDC has recommended HCW immunization for influenza since 1981.
  - JCAHO has established an infection control standard to address influenza vaccine for staff.
    - As of January 1, 2007, JCAHO has required hospitals to offer influenza vaccination to staff with close patient contact. This requirement includes volunteers and licensed independent practitioners.
    - Immunization rates and reasons for declination of vaccine must be evaluated.
    - Education about influenza, immunization, and non-vaccine control measures are required.
- Legislative activity
  - Several states currently have legislation indicating healthcare workers take an annual flu shot or sign a declination form indicating why they are not taking it.
  - Anecdotal reports indicate that in some states patient safety groups are pushing for legislation to mandate healthcare workers take an annual flu shot,

STATEMENT OF POSITION:
The American Nurses Association *Code of Ethics for Nurses* and the Florida Nurses Association support the vital role nurses play in protecting their patients and themselves.

RECOMMENDATIONS FOR ACTION: That the Florida Nurses Association will:
1. Support the CDC and Joint Commissions recommendations that healthcare workers compliance in taking the flu vaccine voluntarily annually increase.
2. Provide information/education regarding seasonal and pandemic influenza through pamphlets, newsletters, mailings and continuing education programs.

3. Gain support of other Florida nursing organizations (e.g. members of Quinn Council) in promoting the importance of influenza vaccinations.

REFERENCES:

Pearson, M. L., Bridges, C. B., & Harper, S. A. (2006). Influenza vaccination of health-care personnel: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the Advisory Committee on Immunization Practices, MMWR, 55, (RR-2), 1-16.

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Thompson, W.W, Shay, D.K., Weintraub, E., Brammer, L, Bridges, C. B., Cox, N., & Fukada, K. (2004). Influenza-associated Hospitalizations in the United States, *JAMA, 292*: 1333-1340.

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PAST ANA HOUSE ACTIONS:

"Everyone Deserves a Shot at Fighting Flu" campaign launched 2005

"Flu Backgrounder" report, poster and Q & A reference developed 2006 – 2007

PAST FNA HOUSE ACTIONS:

None

Adopted by the House of Delegates

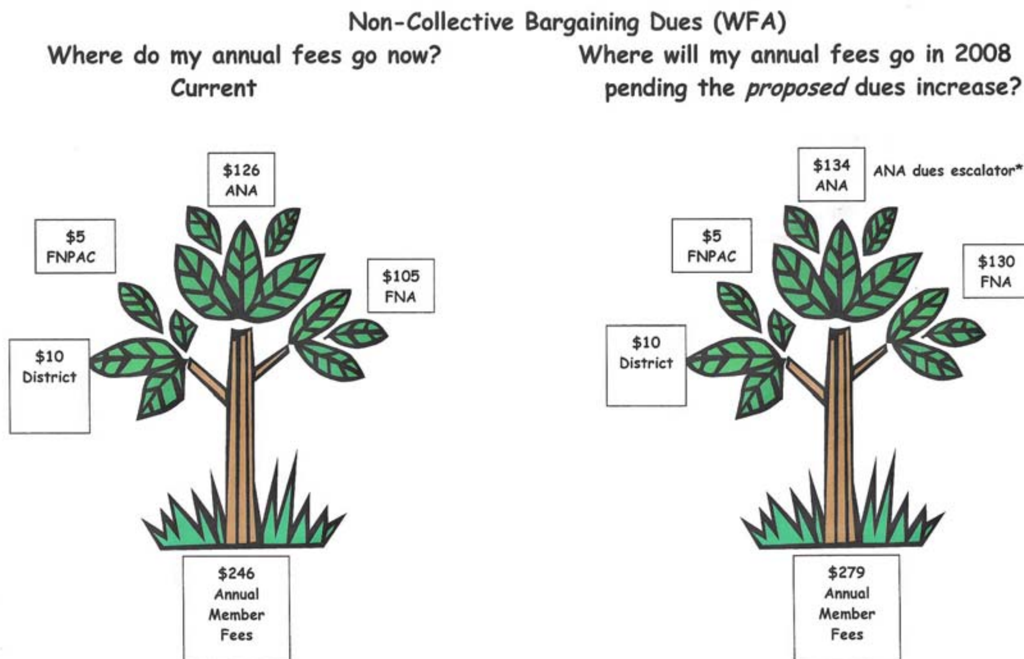
Saturday, September 29, 2007

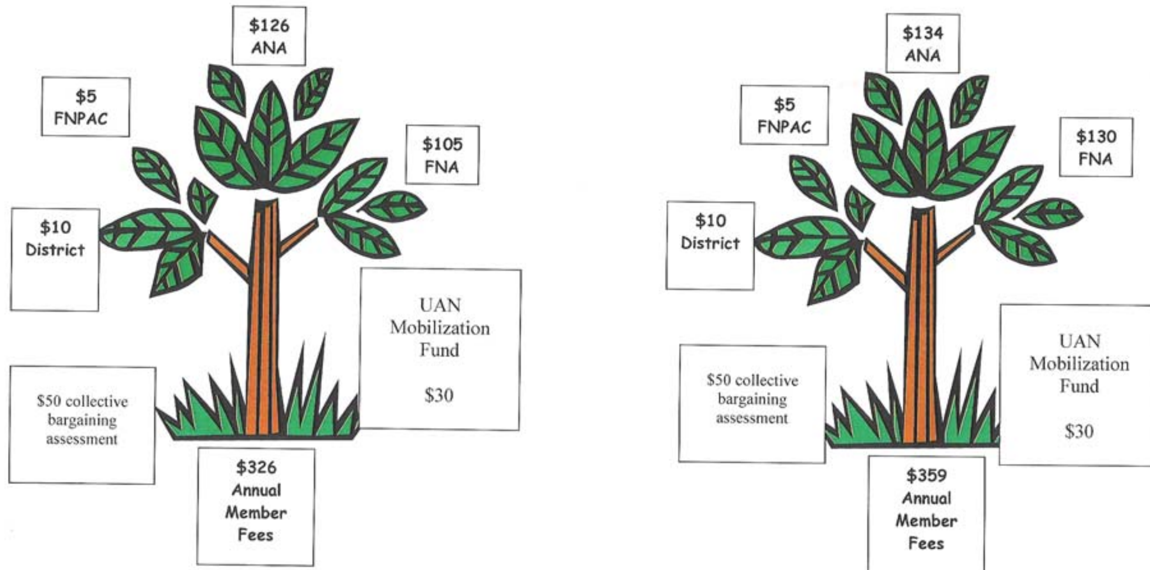
Dues Increase Information

The FNA portion of ANA dues had not been increased since 1992. In those years FNA maintained and supported association activities through dues, non-dues revenue and careful spending. The royalties from the Bank of America (formerly MBNA) credit card served as the FNA reserve fund with a little over $1,000,000 at its highest level. Over the past few years as membership stabilized, revenues were gradually reduced as expenses and the cost of operations increased, the Board of Directors made the decision to utilize the royalties as a part of the operating fund to create a balanced budget for the association. At the same time, the amount if royalties decreased based on market trends such as decreased spending.

It was only logical to request a dues increase to keep pace with the market and to allow our association to continue to thrive and function at a high level providing membership support, programs and advocacy activities at a state and national level.

The dues increase was discussed at length by the delegates and was ultimately passed by the House. Please see the graphics below to assist you with understanding the rate increase.





This dues increase will allow the association to continue at it present level of functioning and perhaps halt erosion of the reserve funds. For any questions, regarding the dues increase please don't hesitate to contact FNA headquarters.

Meet the New BOD...

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2007 - 2009

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