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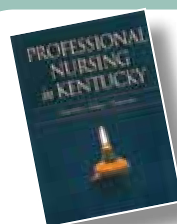

Professional Nursing in Kentucky
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President's Pen

Leadership, Labels And Forging Our Future

Kathy Hall

Critical thinking and communication are key ingredients for employee success in our future leaders. In serving on an advisory committee for a middle school project, I learned how education is changing. The Challenge: let's think of a project that helps seniors continue to live strong engaging lives. I was amazed as the eighth grade science teacher enforced to the students the importance of asking questions, performing research, and recognizing each new idea with "Excellent!" This team of 10 students was exploring Senior Solutions: how to keep senior citizens independent, engaged, and connected. By surveying family and friends, issues facing seniors were identified. Results revealed that a majority of seniors were concerned about caring for their pets as they aged. Students discovered that having pets in the home can positively affect health. The students invented the "Ninja Chucker", a dog toy/food dispenser, assembled from recycled items. These novice investigators created a formal presentation with survey results, research facts and a generous dose of creativity. In the regional competition, this group placed first due in large part to promoting a positive environment, strong parental support and expecting best outcomes. Are these our future researchers and scientists?

The above scenario reminds me how "labels" make a difference. Do we expect the best from our students, colleagues and other healthcare professionals or do we think we are in competition for the same limited resources, honors and recognitions? Do we value the input of others who bring different perspectives to an issue? In a professional organization several years ago, quarterly meetings were dissolving into "gripe sessions". Then a new leader took the helm, and at the end of that individual's first meeting said, "Let's share our success stories-what's going on in your institution?" By pivoting the focus, the energy in the room shifted and success stories became a standing agenda item.

Where will nursing be in the future, and how will we get there? This year as in the past, the *Richmond Register* featured a special section running pictures of each kindergarten class in the county that will become the graduating class of 2026. Each student was asked to complete the sentence: "When I grow up, I want to be a ___." This information is insightful. Of 919 children entering Madison County Schools this year (now first graders), the following are the top 5 careers identified: police officer (15%), teacher (12%), doctor (8%), veterinarian (7%) and firefighter/EMT (5%). Only 19 youngsters indicated they wanted to be a nurse, ranking behind action heroes/Disney characters. One student wants to become president. Now is the time to nurture future nursing leaders to create a diverse workforce.

I am a registered nurse first, followed by my specialty. In this election year it is critical regardless of party affiliation that nurses make legislators aware of what our profession brings to a healthy community. Advanced practice registered nurses provide access to quality health care in clinics and rural settings. School nurses provide early intervention through comprehensive programs. Medical surgical nurses provide acute care for patients with complex medical conditions and increasingly shorter lengths of stay. Nursing faculty members prepare future nurses for a variety of roles.

In forging the future, expert nurses are needed at the table, offering insights that only nurses can provide. How education is delivered will change. Redesign of health care is inevitable. Funding for education and health care at both state and national levels is critical. Collaboration among all nursing specialties assures nursing's voice will be heard: there is power in numbers. ANA/KNA is here to serve, and your leadership talent makes a difference-join us! I am reminded of a line in the poem by Robert Fulghum, *All I Really Need to Know I Learned in Kindergarten*, … "13. When you go out into the world, watch out for traffic, hold hands, and stick together": great advice! Your seat is waiting at the 2014 KNA Convention October 9 and 10. Keynote is Becky Patton, Past President of the American Nurses Association who worked with two different White House administrations, and Kentucky Nurse Leaders will be presenting. We're excited to welcome you there!

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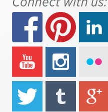

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DATA BITS

This Emergency Department is So Crowded…I'll Never be Seen!

Jessica Gatterdam, BSN Student at Bellarmine University, Louisville, KY

Whether as a patient or as a family member or friend of a patient, it is very likely you have visited the Emergency Department (ED) of a hospital and understand the frustration of long wait times and crowding. If you have felt and experienced this frustration, you are not alone. Emergency department crowding is a nationwide problem and a priority for hospitals and directly impacts the timely treatment of patients requiring emergency care. The industry standard is for patients to be placed in a bed in one hour or less after the decision has been made to admit them to the hospital. Yet this is not occurring and admitted patients being held in the emergency department has been found to be one of the main causes of crowding in the ED.

A recent study by a group of nurse researchers was performed to examine whether the establishment of a Logistics Management Program (LMP) would be effective in minimizing the overcrowding of a suburban hospital ED. In the past, other strategies, including a bed management process, had been implemented to address patient flow in the ED, but nothing had made a notable improvement. The LMP, an expansion of the bed management process, implemented a streamlined approach to tackle the issue of patient flow management by creating a position for registered nurse (RN) logistics managers. These individuals took a "hands on" approach, working directly in the clinical setting to efficiently place patients in inpatient rooms while also serving as a "middle-man" to communicate with patients and families, keeping them updated on the patient's transfer to the appropriate floor. The purpose of this study was to assess an intervention that used a logistics management strategy throughout the hospital to alleviate crowding in the ED by examining the effects of an LMP on ED length of stay, as well as inpatient length of stay (IPLOS).

The quasi-experimental study was conducted in a suburban, 600-bed, tertiary medical center and examined 28,684 ED admissions before and after implementation of an LMP (2008 vs. 2009). Data were selected for the inpatients admitted through the ED only. The treatment group consisted of patients admitted in 2009 [admitted after the implementation of the intervention (LMP)], while the control group was comprised of patients admitted during 2008. Study data came from the collection of information from two patient databases: the electronic medical record for all ED-specific encounters, and the hospital financial system. The primary outcome measures of this study were ED length of stay (including ED evaluation times and ED placement times), as well as inpatient length of stay (IPLOS).

The researchers found that the median ED evaluation times for 2008 versus 2009 were 219 minutes and 207 minutes, respectively ($p < .001$). In addition, the median ED placement times were 219 minutes for 2008 and 193 minutes for 2009 ($p < .001$). Although improvement was statistically significant in both cases, only the difference in ED placement time was clinically relevant when they used a 60 minute or greater decrease in either median or interquartile range time as a benchmark. The median IPLOS times were 3.93 days for 2008 and 3.83 days for 2009 ($p < .001$). Although this seems minimal, the difference of 0.1 days translates into a cumulative difference of 1,483 inpatient days for 2009. The results confirmed that the LMP did have a statistically significant effect on decreasing all event times.

In summary, the study provided strong statistical evidence to support the claim that the innovation of an LMP is associated with a decrease in the ED evaluation times ($p < .001$), ED placement times ($p < .001$), and to a certain extent, IPLOS ($p < .001$). The researchers of this study suggest that the implementation of an LMP resulted in positive outcomes as a strategy to address ED overcrowding, but recognize that the LMP concept needs further testing before it can be recommended as a best practice for reducing patient boarding in EDs.

Source:

Healy-Rodgriguez, M.A., Freer, C., Pontiggia, L., Wilson, R., Metraux, S., Lord, L. (2014). Impact of a logistics management program on admitted patient boarders within an emergency department. *Journal of Emergency Nursing, 40,* 138-145. http://dx.doi.org/10.1016/j.jen.2012.12.008

Data Bits is a regular feature of *Kentucky Nurse.* Sherill Nones Cronin, PhD, RN-BC is the editor of the Accent on Research column and welcomes manuscripts for publication consideration. Manuscripts for this column may be submitted directly to her at: Bellarmine University, 2001 Newburg Rd., Louisville, KY 40205.

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Student Spotlight

Family Presence During CPR: The Impact on Emergency Room Staff

Elizabeth Yoder, Student Nurse
University of Kentucky College of Nursing
Lexington, Kentucky

Mentor: Frances Hardin-Fanning, PhD, RN

Nursing Problem

Family presence during resuscitation or trauma is becoming common practice in many hospital emergency rooms. Research shows that families cope better with the death of a patient if they were present during resuscitation (Baumhover & Hughes, 2009; Downer & Kritek, 2013; Fell, 2009; Jones, Parker-Raley, Maxson, & Brown, 2011; Lowry, 2012). However, family presence during resuscitation can be problematic if emergency rooms and intensive care units become very crowded and chaotic. While family presences may be more emotionally beneficial to the family, little is known about the impact of family presence during resuscitation on nursing staff.

It is estimated that only about 5% of emergency departments have policies related to family presence during resuscitation (Kingsnorth, O'Connell, Guzzetta, Edens, Atabaki, & Mecherikunnel, 2010). Because there are so few policies in place, there is little research on the views of staff members who work with families during resuscitation. If more policies are in place, the staff may be more knowledgeable about the positive impact of family presence during CPR and less concerned with any potential negative consequences. The purpose of this literature review is to explore the perceptions of nurses and other emergency personnel when families are present during resuscitation efforts.

Methods of Review

The databases PubMed and CINAHL were used to search current evidence. Search terms were "family presence resuscitation," and "family presence CPR." Only those articles published within the last five years were reviewed. Articles were excluded if the primary focus was on how family members are impacted by their presence during resuscitation.

Summary of Evidence

Nursing and emergency staff members are often concerned about the presence of family members during the resuscitation efforts. The majority of evidence reports significant staff concerns about family presence during CPR (Agard, 2008; Baumhover & Hughes, 2009; Colbert& Adler, 2013; Cottle & James, 2008; Downer & Kritek, 2013; Fell, 2009; Fulbrook, Latour, Albarran, de Graaf, Lynch, Devictor, & Norekval, 2008; Itzhaki, Bar-Tal, & Barnoy, 2012; Jabre, Belpomme, Azoulay, Jacob, Bertrand, Lapostolle, & Tazarourte, 2013; Jones, et al., 2011; Leung, & Chow, 2012; Lowry, 2012; Meert, Clark, & Eggly, 2013; Sheng, Lim, & Rashidi, 2010). Six main themes of staff concern emerged from the literature: a) threats of legal consequences, b) increased stress experienced by the staff c) delayed resuscitation, d) disruptions/ distractions, e) emotional strain on the family, and f) family members' lack of knowledge about resuscitative procedures.

The most frequently reported concern was the perceived threat of legal issues that may result from the family watching the performance of cardiopulmonary resuscitation (CPR) by the staff. Emergency personnel often perceive that family members might not understand all of the roles of health care members during resuscitation, and subsequently, have concerns that family members may be more apt to sue the hospital and the health care team members (Colbert & Adler, 2013; Downer & Kritek, 2013; Fell, 2009; Itzhaki, et al., 2012; Jabre et al., 2013; Jones, et al., 2011; Leung & Chow, 2012; Meert et al., 2013). Staff members are also worried that the outcome of the resuscitation effort will influence how the family members view the overall experience. If the resuscitative efforts are unsuccessful, staff worry that family members may see this as a failure of the medical team to aggressively treat the patient (Itzhaki, et al., 2012). This scrutiny of staff by the family members, whether real or imagined, results in additional stress for some staff members.

Performing CPR is a very stressful situation for all members of the medical team to undergo. Personnel often view the presence of family as a factor that could compound this stress (Itzhaki, et al., 2012; Jones, et al., 2011; Leung & Chow, 2012; Meert et al., 2013). When emergency personnel are under additional stress, they may be concerned that they are not able to perform at their optimum level.

Personnel also express concerns that family presence can contribute to delayed resuscitative efforts (Downer & Kritek, 2013; Fell, 2009; Fulbrook, et al., 2008; Itzhaki, et al., 2012; Jones, et al., 2011; Meert, et al., 2013). When families choose to be present during resuscitations, there is often a chaplain or other trained professional who can focus specifically on the needs of the family. The need for emergent attention during a resuscitation can result in no one being available to care for the family members. At times, some members of the medical team provide care to family members as well as the patient undergoing resuscitative efforts. If family members are left unattended, they may be more likely to cause distractions and interrupt the resuscitative efforts, which can cause resuscitation to be delayed because they are taking time from someone who should be focused strictly on the patient. This dual responsibility of providing care to both family members and to the patient can prolong resuscitation (Itzhaki, et al., 2012). Interrupting the process to provide care to a patient's family may delay resuscitative efforts (Colbert & Adler, 2013; Downer & Kritek, 2013; Fell, 2009; Fulbrook, et al., 2008; Jones, et al, 2011). Without specific personnel designated to provide care to the family, disruptions may occur with potential increased risk for a failed resuscitation (Downer & Kritek, 2013).

Another concern expressed by emergency personnel is the emotional toll on family members (Colbert & Adler, 2013; Downer & Kritek, 2013; Fell, 2009; Fulbrook, et al., 2008; Itzhaki, et al., 2012; Jones, et al., 2011; Meert, et al., 2013). Although evidence shows that families present during CPR suffer from fewer post-traumatic stress disorder (PTSD) symptoms than families absent during CPR, many nurses may be unaware of this positive effect on families (Jabre, et al., 2013). It is also important to take into consideration that everyone copes and handles situations differently, with some family members needing additional care following the experience of witnessing an unsuccessful resuscitation effort.

Nurses and other emergency personnel also report concerns related to family members not comprehending the interventions conducted during resuscitation (Jones, et al., 2011; Leung & Chow, 2012; Meert, et al., 2013). To the lay individual, resuscitative efforts can appear chaotic due to the number of personnel on the scene, the frequency of medication administration and the numerous procedures often performed. The atmosphere during a resuscitation can be very confusing to a family member, who may have questions or concerns due to their lack of prior exposure to emergency situations. The person taking care of the family can answer these questions, but if there is no designated personnel, the family may interrupt personnel to ask questions. These distractions can potentially delay or prolong resuscitation (Leung & Chow, 2012). Many concerns expressed by staff are interrelated and often times when one concern is realized, it can potentiate other concerns.

Emergency personnel also have positive perceptions of family presence during resuscitation. Family presence can be beneficial because it is helpful with translating, providing information to the nursing and emergency

Family Presence continued on page 5

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Student Spotlight

Family Presence continued from page 4

personnel, offering familiarity and support to the patient, and easing bereavement following an unsuccessful resuscitation (Baumhover & Hughes, 2009; Downer & Kritek, 2013; Fell, 2009; Jones, et al., 2011; Lowry, 2012). By witnessing the resuscitation efforts, family members are able to see that everything possible was done to provide the best care to their loved one (Lowry, 2012).

Clinical Application

Nursing and emergency staff members have expressed several concerns related to families being present during resuscitation. Despite these concerns, there is ample evidence that family presence during resuscitation benefits family members. Nursing and emergency staff need to be aware of these benefits. Educational programs that focus on the positive aspects of family presence during resuscitation have the potential to improve both family and personnel outcomes. Erroneous perceptions of the negative impact of these policies should be addressed through these classes. Competencies that include care for the family during and after CPR, as well as simulation scenarios that provide practice opportunities may help to dispel some of the concerns expressed by staff. An evidence-based committee should be formed at the beginning of this process to ensure that all of the interventions and education are based on the most current nursing research. These committees should be multidisciplinary to guarantee input from all areas that are involved in patient resuscitation. The final implementation of the policy would be to designate a chaplain or other staff member who is not involved in the resuscitation, to be with the family members. Competencies can be developed to provide personnel with the appropriate knowledge and skills to ensure that family members receive care during these often traumatic situations.

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Student Spotlight

Examining the Impact of Anxiety on Preterm Birth

Christina Thompson, B.S.N. Student
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Preterm or premature birth is a leading cause of morbidity and mortality in infants worldwide, affecting nearly 500,000 infants born in the United States. It accounts for about a third of all infant deaths and is the leading cause of neurological disabilities in children (CDC, 2013). Rates of preterm birth have continued to rise steadily over the past 20 years and are extremely high in the U.S. compared to other developed countries (Orr, Reiter, Blazer, & James, 2007; Dunkel Schetter, 2011). It is imperative to identify causes of preterm birth that may occur during pregnancy, especially those that may be preventable. Psychosocial research in pregnancy is evolving as a key factor in the health and development of the baby. One of the most significant contributing factors to preterm birth appears to be pregnancy-related anxiety (Dunkel Schetter & Tanner, 2012; Kramer et. al., 2009). Although understudied, many pregnant women report experiencing anxiety at least some point throughout pregnancy (Lee, Lam, Sze Mun Lau, Chong, Chui, & Fong, 2007). Though there are many gaps and variations throughout the research, it is necessary to examine the impact that maternal anxiety during pregnancy plays on birth outcomes, such as preterm birth.

A systematic search of many computerized databases was performed, including PubMed, MEDLINE, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL) from the time period of within ten years of the date the search was conducted. The following search terms were used to search all databases: *anxiety* or *anx**, *preterm birth* or *premature* or *PTB, preg*, anetenatal,* and *measure*. In addition, the reference lists of papers included in this research were searched. Inclusion criteria were that published studies were written in English, had a sample of humans only, and included women in the antenatal or postnatal period (up to one year postpartum). Types of articles searched were multicenter studies, meta-analysis, journal articles, and clinical trials. Terms excluded from the search were *depression, disorder, smoking* and *alcohol consumption.* A number of studies looked at anxiety, stress and depression collectively, while discussing their individual effects on birth outcome separately in the paper. These studies were included for the sake of their specific information about anxiety influencing birth outcomes.

The majority of the current research points to the idea that there is a strong correlation between maternal anxiety during pregnancy and preterm birth. Although characterization of anxiety varied across the studies, it was commonly defined as the emotional response to stress (Catov et. al. 2010). Many studies pointed out the difference between examining general anxiety and pregnancy-related or pregnancy specific anxiety (Dunkel Schetter, 2011; Dunkel Schetter & Tanner, 2012; Kramer et. al. 2009). Dunkel Schetter (2010) defined pregnancy anxiety as a syndrome in which the concerns of the mother are centered around the health and well-being of the baby, birth and postpartum, and health-care experiences. Zelkowitz and Papageorgiou (2012) noted that self-perceived anxiety was more associated with adverse outcomes, like preterm birth, than a diagnosed anxiety disorder.

Significant connections were found between pregnancy anxiety and the timing of delivery. Pregnancy-related anxiety was universally associated with a shorter gestation and often implicated high risk for preterm birth (Dunkel Schetter & Tanner, 2012). Dunkel Schetter (2011) cited three prospective studies in different geographical locations that used the same anxiety measure and yielded the same result: anxiety related to pregnancy had more significant effects on preterm birth. A commonly cited study throughout the literature was performed by Kramer et. al. (2009) and stated that women with high anxiety during pregnancy were 1.5 times more likely to experience preterm birth; controlling for socio-demographic covariates, medical and obstetric risks, and high risk pregnancy conditions. For women who delivered preterm, the mean of anxiety and perceived stress was highest in the third trimester (Glynn et. al., 2008). The severity and duration of anxiety predicted a shorter gestation, with the highest anxiety levels in the third trimester of pregnancy even after controlling for cofounding variables (demographics, social, substance abuse, medical and psychological history) (Hosseini et. al., 2009). Many women experience anxiety at some point and it can occur at any time during their pregnancy. More than half of the pregnant women in a study conducted by Lee et. al. (2007) had an elevated anxiety level at one or more points in time, indicating that screening just one time during prenatal care is not sufficient. Nurses are at the forefront of identifying at-risk women and implementing appropriate interventions because of their extensive background in holistic care (Lederman, 2011).

The evidence supports the need for the clinical screening of anxiety symptoms in pregnant women. Ideally, attempts to identify at-risk women would begin before conception. Lederman (2011) points out that although assessment of anxiety should be included across the disciplines, nurses possess a unique advantage in this assessment as evidenced by their training and interaction with the woman. Women can report experiencing anxiety at only one or two times rather than throughout the entire pregnancy. It is imperative that on-going screenings are conducted in women throughout each trimester, because "it is dangerous to exclude a case of probable antenatal anxiety [with] information from only one antenatal visit" (Lee et. al., 2007, p. 1109). Some factors appear to be consistent predictors of anxiety in women defined as high-risk. Young age, marital status, unwanted pregnancy, and self-esteem are a few variables that are associated with higher levels of anxiety (Lee et al., 2007). Although screening for anxiety in the prenatal period is often widely recommended, problems arise in regards to the type of screening tool used, criteria for identifying high-risk women, and adequate follow-up with appropriate clinicians (Dunkel Schetter &Tanner, 2012). There are many tools that can be used to screen for anxiety, but they differ widely in their style and validity. Confusion occurs when assessment tools measuring anxiety and other psychosocial conditions together are used in screening (Dunkel Schetter & Tanner, 2012).

After high risk women have been identified, interventions also need to focus on promoting effective coping skills during pregnancy. Poor coping strategies to manage anxiety during pregnancy appear to increase a woman's risk to experience negative birth outcomes (Dunkel Schetter, 2011). Coping mechanisms that were used

Impact of Anxiety continued on page 7

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Student Spotlight

Impact of Anxiety continued from page 6

before pregnancy may not help to reduce the specific anxiety felt by the woman during pregnancy. The development of effective coping techniques in pregnant women has to be individualized and include going out with friends, relying on spiritual or religious guidance, and talking with a therapist or other expert. Research suggests that social support during pregnancy is associated with better birth outcomes (Dunkel Schetter, 2011).

Because an increasing amount of evidence supports that adverse birth outcomes are associated with high levels of anxiety in pregnant women, non-pharmacologic interventions need to be primarily considered. Pharmacologic interventions are limited in pregnancy because of their side effects and the risk for harm to the fetus (Newham, Westwood, Aplin, & Wittkowski, 2012). Mann et. al. (2008) found that non-pharmacologic interventions such as religiosity and spirituality were significantly associated with lower anxiety in pregnant women. Implementation of group care or participation in CenteringPregnancy may help identify women at risk for experiencing pregnancy anxiety and carry out interventions more effectively. CenteringPregnancy® is prenatal care that combines the concept of childbirth classes with a medical appointment in a group setting with other pregnant women (Walker & Worrell, 2008). Through this type of group discussion, women learn their problems are not unique and can receive support from others with similar experiences (Walker & Worrell, 2008). Where childbirth classes focus mainly on the experience of labor and delivery, CenteringPregnancy expands upon the birth experience by including classes on health habits, self-esteem and satisfaction, stress management, and anxiety reduction (Walker &Worrell, 2008

Further research needs to be conducted into the pathophysiology as to why anxiety is a risk factor of preterm birth. Evidence suggests that the relationship between anxiety and preterm birth is a result of an alteration in the maternal and fetal hypothalamic pituitary adrenal (HPA) axes. Dunkel Schetter & Tanner (2012) report that, "Maternal mood disorders have also been shown to activate the maternal HPA axis and program the HPA axis and physiology of the fetus" (p. 144). Maternal serum or plasma corticotropin-releasing hormone (CRH) has been found to be a marker consistent with preterm birth (Kramer et.al., 2009). One study found a positive correlation between an elevated level of maternal CRH and pregnancy-related anxiety. Some studies point to a correlation between cortisol and anxiety levels, but there is a lack of consistency in the results concerning this relationship (Zelkowitz & Papageorgiou, 2012). Other biological explanations for the link between anxiety and preterm birth must continue to be explored in order for the most effective interventions to be created.

Anxiety in pregnancy is a significant problem that has been shown to increase the risk of experiencing preterm birth. Though there are many ideas as to how exactly preterm birth results, the exact mechanism is still unknown. Pregnant women should be screened throughout pregnancy and interventions should be individualized based on the triggers of anxiety. It is also important to reduce the stigma surrounding anxiety disorders and seeking treatment. Anxiety can cause serious problems during pregnancy and needs to be addressed prenatally throughout all healthcare settings.

Student Spotlight is a regular feature of *Kentucky Nurse*. Donna Blackburn PhD, RN is the editor of the Student Spotlight and welcomes student-authored manuscripts for publication consideration. Manuscripts for this column may be submitted electronically to her at: donna.blackburn@wku.edu.

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Frontier Nursing University Celebrates 75 Years of Blazing New Frontiers as Pioneers for Healthcare

Frontier Nursing University (FNU) is celebrating 75 years of educating nurses to become nurse-midwives and nurse practitioners. Mary Breckinridge founded the Frontier Graduate School of Nurse Midwifery on a model of public health nursing and nurse-midwifery which she saw as an answer to decreasing maternal mortality and improving health care in rural areas. Her work was dedicated to the children in rural areas and she started the Frontier Nursing Service (FNS) in a remote rural area of Kentucky in 1925. In her book *Wide Neighborhoods* Mrs. Breckinridge states, ".. work for children should begin before they are born, should carry them through their greatest hazard which is childbirth and should be the most intensive during their first six years of life. These are the formative years-whether for their bodies, their minds or their loving hearts." (Breckinridge, page 111)

Her plans when she started FNS were to start a school for nurses to become trained in public health and nurse-midwifery. In 1939 the British nurse-midwives who helped create FNS were leaving to support the war effort at home. This prompted the creation of the school. The term nurse practitioner would not be created until 1965 but Mrs. Breckinridge knew that if she wanted to care for rural children the nurses needed to be able to take care of the whole family and the community in which the family lived. The nurses were educated to care for the entire family but the emphasis was maternity care. In 1970 the name of the school was changed to the Frontier School of Midwifery and Family Nursing to incorporate the formalization of the first family nurse practitioner program in the country. In 2011 the name was changed to Frontier Nursing University (FNU).

The legacy of Mrs. Breckinridge continues today through the graduates of FNU. Registered nurses from all over the country travel to Hyden, Kentucky to begin their studies as either nurse-midwifery or nurse practitioner students. The students at FNU have a commitment to improve healthcare for the mothers, babies, women and families in their communities. The trip to the historic FNU campus for orientation builds a community of learners that have an understanding of the legacy of the university and the confidence to complete their studies in their own communities via a distance learning format. Innovative teaching strategies designed by a faculty of expert nurse-midwives and nurse practitioners are utilized to educate students at a distance in online courses. FNU is a leader in distance education and has been providing education at a distance since 1989.

Students at FNU are engaged in learning with each other and the faculty to create deeper learning in an online environment. Interaction between the faculty and the students is done through creative instructional design that supports the learner and provides a platform for virtual learning. The students return to campus after completing the didactic portion of their studies for a hands-on learning experience prior to working side by side with nurse-midwives, nurse practitioners and physicians in their clinical practicum to apply their knowledge to care for mothers, babies and families in their home communities. Students completing their doctoral studies have the opportunity to work with content experts that deepen their knowledge of their chosen healthcare issue.

FNU offers degrees for registered nurses (RNs) to complete the Master of Science in Nursing (MSN) and a Doctor of Nursing Practice (DNP). There is also a path for RNs with an associate degree to enter the program through an ADN Bridge Entry Option. Graduates of the programs successfully complete the certification exams for nurse-midwifery, family nurse practitioner or women's health care nurse practitioner specialties.

Throughout the past 75 years, FNU has evolved from a school to a premier nursing university that educates nurses to become nurse-midwives and nurse practitioners to improve healthcare in their communities. Currently 70% of 1,500 FNU students live in rural or underserved areas. There are nearly 4,000 nurses that are graduates from Frontier. These graduates are nurse-midwives and nurse practitioners that demonstrate daily that high quality, cost effective health care improves health outcomes and provides access to health care for mothers, babies and families. FNU proudly celebrates the legacy of Mary Breckinridge and her vision to care for the children in rural areas and "wide neighborhoods of man."

Breckinridge, M. (1952) Wide Neighborhoods: A story of the Frontier Nursing Service. Harper & Row, Publishers: New York.

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Universities in Kentucky Receive Funding

Frontier Nursing University has been awarded continuation funding from the Health Resources and Services Administration's Programs Scholarship for Disadvantaged Students and the Nurse Faculty Loan Program. The Scholarship for Disadvantaged Students Program, originally awarded at a total of $1,350,000 over a 4 year period, has been renewed for 2014-15 in the amount of $366,000. The purpose of the SDS Program is to increase diversity in the health professions and nursing workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to financially needy students from disadvantaged backgrounds.

More than a dozen **University of Louisville School of Nursing** master's degree students will receive substantial assistance to pay for their education. The Health Resources and Services Administration has awarded the school a two-year $670,000 Advanced Nurse Education Traineeship Grant to help 15 current and new family nurse practitioner (FNP) and adult-gerontology nurse practitioner (AGNP) students pay for tuition, books, program fees, and living expenses. The first cohort of trainees begins in August 2014.

Western Kentucky University School of Nursing Graduate Program was awarded the Advanced Education Nursing Traineeship (AENT) for 2014 to 2016. In the academic year 2014-2015, a total of $223,030 will be awarded to MSN and DNP students pursuing degrees for family nurse practitioners and/or psychiatric-mental health nurse practitioners.

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Kentucky's Improvement in Administering Tdap for Adolescents:

The National Immunization Survey-Teen 2008-2012

John Myers, MSPH PhD
Associate Professor, Bioinformatics and Biostatistics
Child and Adolescent Research Design and Support (CARDS)
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The Advisory Committee on Immunization Practices (ACIP), since 2005, has recommended that routine administration of Tetanus-diphtheria vaccine (Td) be replaced by administration of one dose of the tetanus toxoids reduced diphtheria toxoids-acellular pertussis vaccine (Tdap) for teenagers (Borders et al., 2006). In this paper, we discuss Kentucky's disproportionate increase in adherence with these recommendations, resulting in Kentucky closing the gap on the Nation and all other states for providing Tdap to adolescents.

Methods

Study Population

The National Immunization Survey-Teen (NIS-Teen), conducted by the CDC's National Center for Health Statistics, collects data concerning immunizations for adolescents 13-17 years of age. To ensure data quality the NIS-Teen contacts all adolescents' vaccination providers to assure the accuracy of the vaccination data. Types of immunizations, dates of administration, and additional data about facility characteristics are collected. Data for each year are weighted to provide a representative sample of teenagers throughout the United States. De-identified NIS-Teen data are publicly available through the Centers of Disease Control and Prevention (http://www.cdc.gov/nchs/nis/data_files_teen.htm). As a result, this study received IRB exemption from the University of Louisville.

Statistical Analysis

A serial cross-sectional study design was used to calculate three outcomes, stratified by year (2008 vs. 2012) and state: (1) rate of Tetanus Containing Vaccine [TCV] administration in adolescents, (2) rate of Tdap administration in adolescents, and (3) rate of Tdap administration conditional on a TCV being administered ("conditional Tdap"). This allowed us to evaluate if Kentucky has made disproportionate improvements in Tdap and conditional Tdap administration over time when compared with all other states.

Results

Tetanus Uptake Nationally.

The proportion of teens receiving any TCV significantly increased from 2008 to 2012, nationally, from 74.1% in 2008 (95% CI 72.8% - 75.3%) to 88.5% in 2012 (95% CI 87.7% - 89.3%), p<0.001. Tdap uptake among all teenagers also significantly increased over the same time period, from 41.0% (95% CI 39.3% - 42.2%) to 84.6% (95% CI 83.7% - 85.5%) in 2012, p<0.001. Among TCV recipients, the proportion of teens who were still receiving Td rather Tdap decreased from 44.9% in 2008 (95% CI 43.2% - 46.7%) to 4.4% in 2012 (95% CI 3.7% - 5.1%).

Tetanus Uptake for Kentucky.

The proportion of teens receiving any TCV significantly increased from 2008 to 2012, in Kentucky, from 82.0% in 2008 (95% CI 78.3% - 86.1%) to 86.0% in 2012 (95% CI 81.3% - 90.7%), p<0.001. Tdap uptake among all teenagers also significantly increased over the same time period, from 28.1% (95% CI 25.2% - 32.3%) in 2008 to 80.0% (95% CI 74.4% - 85.6%) in 2012, p<0.001. Among TCV recipients only, the proportion of teens who were still receiving Td rather Tdap decreased from 65.8% in 2008 (95% CI 61.8% - 70.3%) to 7.0% in 2012 (95% CI 3.4% - 11.6%).

State-Level Rates.

Although Kentucky provided significantly more TCV in 2008 (82.0% vs. 74.1%, p<0.01) when compared to the nation, Kentucky provided significantly less Tdap in 2008 (28.1% vs. 41.0%, p<0.01). However, in 2012, Kentucky provided Tdap at a similar rate as the nation (80.0% vs. 84.6%, p=0.131).

Similarly, although Kentucky provided less "conditional Tdap" in 2008 (34.3% vs. 55.1%, p<0.01), Kentucky provided similar amounts of conditional Tdap in 2012 (93.0% vs. 95.6%, p=0.258).

Kentucky had significantly larger increases in providing Tdap over time (184.7% vs. 106.3%, p<0.01) as well as conditional Tdap over time (230.9% vs. 73.5%, p<0.01) when compared to the nation.

Conclusion

Kentucky (as well as the Nation) may not need to focus its efforts to ensure providers are providing Tdap, but rather focus on adolescents visiting healthcare providers at recommended intervals.

Kentucky has improved dramatically in its adherence with the ACIP's recommendations for Tdap administration. Kentucky's rate of improvement from 2008-2012 was significantly better than the nation and most other states. As a result, Kentucky now has similar rates of providing Tdap and conditional Tdap, when compared to the nation.

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A Partnership to Enhance Community Health Education for RN to BSN Students

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Abstract:
This article shares a unique model of collaboration between a school of nursing and a community business to offer an on-site occupational health clinical experience for RN to BSN students. This activity could be easily replicated by others to provide a learning opportunity for nursing students.

Hospitals remain the primary site of employment for nurses. However, with health care reform nurses are exploring many new opportunities including many settings in the community (Black, 2014). Incorporating community health into nursing curriculum is a necessity; however, providing meaningful clinical experiences can be a challenge for faculty. To meet students' learning needs, faculty must be open to developing innovative clinical opportunities (Ellenbecker, 2002). This article describes a unique partnership between faculty in a RN to BSN completion program and employees of a local UPS® . The partnership provided an opportunity for students to have a real on-site experience in health education for community members in a nontraditional clinical site. Faculty and employees of the UPS® center's health and safety committee worked together to plan a health fair for employees that took place at the workplace setting.

One of the goals in the 2014-2018 strategic plan of the U.S. Department of Health and Human Services (HHS) is to "Advance the Health, Safety, and Well-Being of the American People" (HHS, n.d. p. 3). Strategies to promote prevention and wellness across the lifespan include educating individuals to adopt healthy lifestyles (HHS, n.d). This activity is just one example of how this can be accomplished.

Description of Project

Students participating in the project were enrolled in a required public health course. The course is comprised of a didactic and clinical component. As part of the clinical component students are required to rotate through various community agencies. This event served as one clinical experience for students. Faculty consulted with representatives from UPS® to identify health promotion topics that would be of interest to their employees. Once topics were established, faculty provided students a list of topics from which they could choose. Students were also given information about the population they would be teaching and the setting in which the health fair would occur. Students worked in groups to prepare a teaching plan that was submitted to a clinical faculty member for approval. The teaching plan included content, delivery method, visual aids, and handouts. Faculty was cognizant of the need for student safety in the community; therefore, students were cautioned about safety on the UPS® lot including such topics as parking and driving on the lot.

To encourage attendance at the health fair, members of the local UPS® health and wellness committee began promoting the event one month in advance. Flyers were posted at the center and employees were reminded of the date and health promotion topics throughout the month at their regular scheduled morning meetings.

On the day of the health fair, students arrived at the local UPS® center in the evening just prior to the time the drivers would be returning to the building at the end of their work day. Each group set up a table with information about a specific, assigned topic. The drivers and other employees were able to obtain information regarding topics such as hypertension, healthy eating, sun safety, diabetes, healthy back, health maintenance, and prostate cancer. Faculty were available throughout the event to observe and mentor students. UPS® provided incentives for attendance including small prizes at each table and entry into a drawing for a larger reward.

Outcomes

Overall, four nursing faculty members and 18 RN to BSN students volunteered to participate in the health fair. Forty-three UPS® employees attended the health fair. Many positive outcomes were noted from this collaborative effort. The most important outcome was the opportunity to provide education to enhance the health and wellness of those that attended. Often barriers for obtaining health services are convenient access and time (Lundy & Janes, 2009). By offering this health fair at the work place and at a convenient time, these barriers were lessened.

The major course objectives this experience related to were examining occupational issues, exploring health care problems, and using nursing research. Students conducted research regarding an assigned health care problem and developed a teaching plan appropriate for a specific population. The American Association of Colleges of Nursing identified nine essentials of baccalaureate education. This activity fosters essential number three, six, and seven. Essential three speaks to the value of evidence-based practice (AACN, 2008). Students participating in the health fair had to research an assigned topic and provide education supported by current evidence of best practice. The value of interprofessional communication and collaboration is noted in essential six (AACN, 2008). Participation in the health fair required incorporating effective communication skills and participating as a team member. This clinical experience supports clinical prevention and population health which AACN (2008) includes in essential seven as required component of baccalaureate nursing education.

This was a valuable opportunity for students as it provided a genuine onsite clinical education experience in occupational health. The project fostered verbal and written communication. Additionally, teamwork skills were cultivated as students worked as a member of a group to develop and present information to attendees.

This event was also valuable to UPS®. Chronic illnesses result in Americans missing 2.5 billion days of work annually. This adds up to approximately one trillion dollars in loss of productivity (Health and Human Services, n.d). Providing education to individuals can result in healthier lifestyles which can aide in preventing much chronic illness which may in return decrease absence from work.

Due to the many faculty roles, it is sometimes a struggle to incorporate service with teaching. This served as an outstanding way to incorporate faculty service with teaching. Faculty also served as role-models for students who observed faculty interacting with others in the community and providing health education to a specific population in a non-traditional setting.

Future Plans

This demonstrated a successful way to provide a community experience for RN to BSN students and also provided easy access to health promotion information for a specific population at the workplace setting. Faculty has plans to continue this activity in this setting and look for similar opportunities in other industries within the community. They also plan to capture the opportunity for evaluation of the experience from the students' and participants' perspective.

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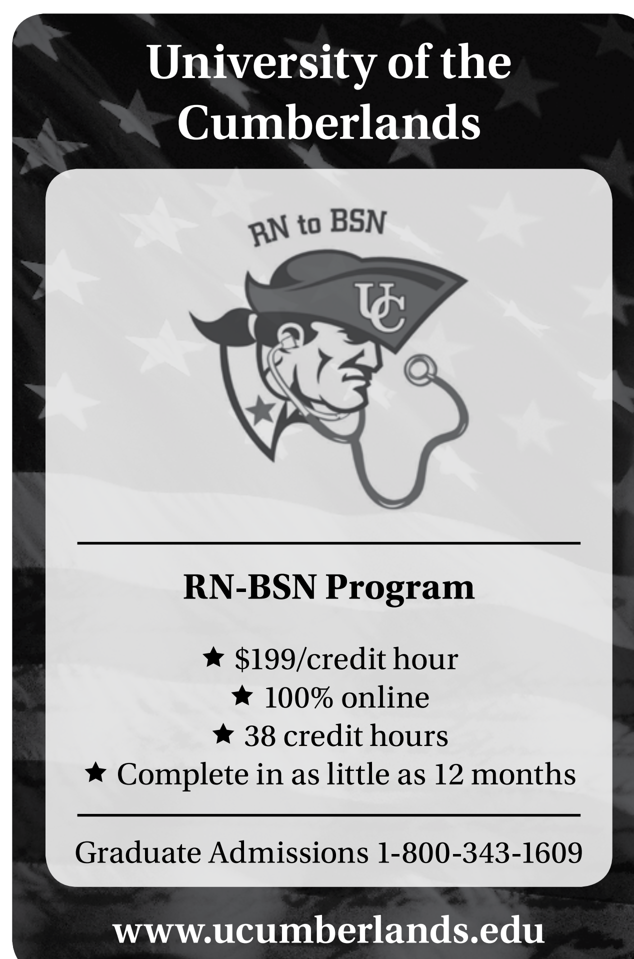

Assessing the Home Fire Safety of Urban Older Adults: A Case Study

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Abstract

Older adults are at a higher risk for fatal house fire injury due to decreased mobility, chronic illness, and lack of smoke alarms. The purpose of this illustrative case study is to describe the home fire safety (HFS) status of an urban older adult who participated in a large study funded by the Federal Emergency Management Agency (FEMA). During a home visit with the participant, HFS data were collected from documents, observation, physical artifacts, reflective logs, and interviews. Numerous HFS hazards were identified including non-working smoke alarms, inadequate number and inappropriate placement of smoke alarms, lack of carbon monoxide (CO) alarms, inability to identify a home fire escape plan, hot water heater temperature set too high, and cooking hazards. Identification of HFS risk factors will assist in the development of educational materials that can be tailored to the older adult population to decrease their risk of fire-related injuries and death.

Key words: Case study, Older adults, Home fire safety

Acknowledgment: This study was funded by Federal Emergency Management Agency Fire Prevention & Safety Grant #EMW-2012-FP-01181 awarded to Dr. Lehna.

Introduction

From January 2011 to November 2012, the Louisville Fire Department (LFD) responded to 552 single dwelling fire alarms in only eight urban zip codes (LFD, 2012). Populous urban environments create unique challenges to home fire safety (HFS) that are compounded by age-related difficulties. Warda, Tenenbein, and Moffatt (1999) found that older adults were at a higher risk for fatal house fire injury. This was attributed to decreased mobility, chronic illness, and lower prevalence of smoke alarms (Warda et al., 1999). Due to the higher risk of severe burn injury and mortality faced by older adults, assessing fire safety knowledge and preparedness in the home is an essential step in prevention. This illustrative case study describes one older adult's HFS knowledge and risk factors in the living environment.

Methods

Design and Sample

The participant for this illustrative case study, Ms. Jones (fictitious participant), an elderly female living alone. She had two chronic illnesses, had fallen three times in the last six months, and lived on a fixed income from Social Security. Ms. Jones completed a knowledge pre-test, viewed a short HFS video, and completed a post-test. A HFS check was conducted using the Home Safety Checklist to evaluate smoke alarms, cooking safety, electrical and appliance safety, candle safety, smoking safety, heating safety, and home escape plan (USFA, ND).

Measures

The participant filled out a demographic questionnaire and a HFS pre- and post-test. Researchers completed the USFA Home Safety Checklist and observed living conditions, HFS hazards, and preparedness measures in the home of the participant. Observations took place before and during the home visit to assess as much of the living environment as possible. With permission of the participant, photographs were taken of safe and unsafe HFS practices to document HFS practices and allow more detailed description of the case. Reflective data were gathered through researcher field notes and team debriefings where the home visit was discussed and analyzed. Notes taken during the home visit further documented the observations and enriched group discussions as details were recorded and not simply recalled. An understanding of the participant's HFS knowledge and risk factors was developed through dialog prompted from the data collection documents. The dialog allowed for a further understanding of the context within which the participant made decisions and managed factors that contributed to HFS. These approaches to data collection captured the participant's major risk factors, HFS knowledge level, and living environment.

Procedure

The university institutional review board approved the study and the participant gave informed consent. The home visit was scheduled according to researchers' and participant's mutual availability; a reminder phone call was placed the day before the visit.

Results

Upon entering the home of Ms. Jones, the researchers quickly determined she had difficulty with mobility. Located in the hallway was one properly functioning smoke alarm; Ms. Jones stated this was the only one on the main level of her house. The only other smoke alarm, without working batteries, was located in the basement. Ms. Jones stated that she did not know what a carbon monoxide (CO) alarm looked like.

There was clutter around the stove (e.g., paper towels, plastic bread bags), pot handles turned towards the front of the stove, and a large amount of cooking grease on the wall behind the stove. The stove hood was not vented to the outside, and the oven was occasionally used as an extra heating source. In the living room was an overloaded power strip and a space heater plugged into an extension cord that ran under the carpet. Ms. Jones indicated she did not use candles or smoke cigarettes. The basement hot water heater was on the hottest setting, above 120°F. The dryer exhaust vent and lint trap were clear of hazardous debris and were properly vented. Ms. Jones did not have an escape plan or a designated meeting place in front of the house in the event of a fire. She knew she should get low to the ground, but asked, "How can I get down on the ground and crawl if I can barely walk?" The researchers discussed home escape planning and other recommendations to improve HFS with Ms. Jones. They reviewed how to safely exit the home during a fire and where to identify a meeting place once outside of the home. They also talked about lowering the hot water heater temperature, proper use of a space heater, and removing flammable materials from around the stove.

Personal characteristics of Ms. Jones also contributed to HFS hazards. These included inability to exit the home in case of a fire due to a history of falls, immobility issues that required use of a walker or wheelchair, and presence of multiple chronic illnesses.

Based on pre- and post-test scores, the discussions with Ms. Jones, and the evaluation of her home, Ms. Jones' knowledge and understanding of her ability to increase her safety and decrease her risk of injury was limited. There was concern for her ability to understand the teaching that occurred during the intervention due to possible dementia and cognition issues.

Discussion

Researchers identified two main themes during the home visit with Ms. Jones. There were HFS hazards in her home and a lack of HFS preparedness. According to the USFA (2012), the temperature on hot water heaters should be set at no higher than 120°F. The hot water heater in the home of Mrs. Jones was set on the hot setting. Older adults are at higher risk of receiving a scald injury from hot water (Leahy et al., 2007). Leahy et al. (2007) found that exposure to scald injuries increased the risk for health complications and subsequent death among hospitalized burn patients who were 60 years and older.

Many cooking hazards were identified in the home of Ms. Jones. These included flammable items near the stove and pot handles turned to the front of the stove. During discussions with Ms. Jones, it was apparent that she did not identify these behaviors as fire hazards indicating a lack of HFS knowledge. This is of particular importance as cooking is the leading cause of house fires (Shields et al., 2013) and older adult injuries (USFA, 2006).

The USFA (ND) recommends installation of properly working smoke alarms on every level of the home and inside and outside each sleeping area. Not all of the smoke alarms found in the home functioned properly nor were they placed throughout the home per the USFA recommendations. Smoke alarms play a crucial role in alerting people of a fire, especially while they are sleeping. Data regarding residential fires indicates that the majority of older adults were injured or died during a fire while they were sleeping (USFA, 2006).

While the USFA (ND) recommends CO alarms less than seven years old on each level of the home, Ms. Jones had no CO alarms in her home. This increases the risk of injury from CO poisoning. An alert system is especially important given that older adults are more likely to attribute symptoms associated with CO poisoning to other health problems, resulting in increased hospitalizations and death (Iqbal et al., 2010).

Ms. Jones was unable to verbalize a fire escape plan. According to the USFA (2006), older adults were injured attempting to escape fires rather than control them. This supports the need for older adults to develop and practice a home fire escape plan.

Conclusion

Older adults' lack of HFS preparedness is an underreported health hazard. HFS education, awareness, and personal actions have the potential to save lives. It is important that HFS education and fire prevention efforts geared towards older adults cover multiple aspects of HFS including: development of a home escape plan; importance of CO alarms; proper installation and care of smoke alarms; proper setting of hot water heater temperature; and safe cooking practices. HFS education should be tailored to meet the needs of older adults by considering mobility limitations, effects of chronic illnesses, learning ability, and living conditions.

Educational instruments and teaching efforts should be customized to specific risk factors faced by older adults, taking into account potential cognitive decline. Isolation, poverty, crime, lack of transportation, and other determinants should be considered when creating realistic goals for HFS education. A nurse providing education at time of discharge or during a primary care visit is potential way to spur changes in HFS behavior.

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9–10 Convention 2014, Holiday Inn Hurstbourne, 1325 South Hurstbourne, Louisville, KY

9 10:00 am-5:00 pm Kentucky Board of Nursing Meeting

9-11 KANS Convention, The Center for Courageous Kids in Scottsville, KY

17 Bluegrass Chapter / formerly District 2 / Nurse Advocacy Conference at Midway College – contact KNADistrict2@gmail.com for more information

November 2014
10 Deadline for the ***Kentucky Nurse*** (January/February/March 2015 Issue)

11 Veterans Day - KNA Office Closed

14 2014 Critical Care Symposium: A Day With Tom Ahrens (Hemodynamics, Sepsis, Capnography and EOL), Baptist East, Louisville, KY. To register: GreaterlouisvillechapterAACN.org

27-28 Thanksgiving Holiday - KNA Office Closed

December 2014
5 10:30 AM – 5:00 PM Kentucky Board of Nursing Meeting

22-31 Christmas Holiday – KNA Office Closed

January 2015
1 – 2 New Year's Day Holiday - KNA Office Closed

19 Martin Luther King, Jr. Holiday – KNA Office Closed

February 2015
16 President's Day Holiday – KNA Office Closed

March 2015
20 Surviving Your First Year of Practice, Clarion Hotel North, 1950 Newtown Pike, Lexington, KY 40511
Overnight Room Block: 859-233-0512

April 2015
10 Surviving Your First Year of Practice, Carroll Knicely Conference Center, 2355 Nashville Road, Bowling Green, KY 42104
Overnight Room Block: Staybridge Inn and Suites, 680 Campbell Lane, Bowling Green, KY 42101
Overnight Room Reservations: 270-904-0480

March 2015

April 2015

May 2015
25 Memorial Day Holiday – KNA Office Closed

June 2015
1 Deadline for the Call to Summit 2015

July 2015
3 Fourth of July Holiday Observed – KNA Office Closed

August 2015
1 KNA Ballot 2015 Mailing

September 2015
7 Labor Day Holiday – KNA Office Closed

October 2015

November 2015
26-27 Thanksgiving Holiday – KNA Office Closed

December 2015
21-31 Christmas Holiday – KNA Office Closed

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1 New Year's Day Holiday – KNA Office Closed

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In Memoriam

Marcia Dake, Ed.D, RN, founding dean of the University of Kentucky College of Nursing, has passed away.

Dr. Dake served in the Army Nurse Corps during WWII and used her GI Bill to complete her master's and doctoral degrees. She was one of the first ten doctorally prepared nurses in the country and in 1958, at age 35, was the youngest dean to serve at a college of nursing in the U.S.

The first baccalaureate class was admitted in the fall of 1960 and at that time nursing was the only undergraduate program at UK to have a selective admissions process. UK's BSN Program was one of only two baccalaureate nursing programs in Kentucky; the others were hospital diploma programs. Under Dr. Dake's leadership the college received full accreditation in 1965 and the master's program was approved by the Faculty Senate in 1969.

Dr. Dake served as dean until 1971 and leaves a legacy that will forever be remembered not only in the College of Nursing but throughout UK's Chandler Medical Center, and by pioneering nursing students who withstood a rigorous, yet excellent nursing program.

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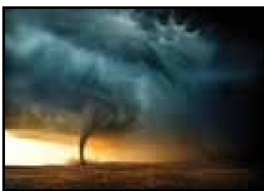

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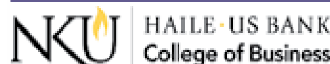

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KNA Centennial Video *Lest We Forget* Kentucky's POW Nurses

This 45-minute video documentary is a KNA Centennial Program Planning Committee project and was premiered and applauded at the KNA 2005 Convention. *"During the celebration of 100 years of nursing in Kentucky—Not To Remember The Four Army Nurses From Kentucky Who Were Japanese prisoners for 33 months in World War II, would be a tragedy. Their story is inspirational and it is hoped that it will be shown widespread in all districts and in schools throughout Kentucky.*

POW NURSES
Earleen Allen Frances, Bardwell
Mary Jo Oberst, Owensboro
Sallie Phillips Durrett, Louisville
Edith Shacklette, Cedarflat

___ **Video Price: $25.00 Each**

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Support KNA and ANA: Advocates for Nurses, Patients and Quality Healthcare

Today more than ever, nurses need advocates to help ensure that critical issues such as safe workplaces, APRN scope of practice and adequate staffing are being addressed. You need advocates to help protect your health and safety, allow you to deliver quality patient care as well as allowing you (if you are an APRN) to practice to the full extent of your education.

That's why it's so important that you support the Kentucky Nurses Association (KNA) and the American Nurses Association (ANA) with your membership. Here in Kentucky, in the Nation's Capital and across the country, KNA and ANA are your advocates – working together and speaking on your behalf.

Earlier this year, the Registered Nurse Safe Staffing Act (H.R.1821), crafted with ANA input, was introduced in the U.S. Congress. As a nurse you know that adequate staffing is important to quality patient care. However, cuts in healthcare budgets along with a growing shortage of nurses results in longer working hours by fewer nurses caring for sicker patients.

KNA has been working to teach nurses and nursing students how to track and understand the legislative process in Kentucky. Through speaking to specialty organizations, nursing classes and other professional nursing groups, the KNA has been providing legislative updates and sessions related to identifying your legislators and communicating effectively with them. Finally, it is the goal of KNA to provide all nursing professionals in Kentucky with the tools necessary to further the Voice of Nursing in Kentucky.

Advocacy, either directly or through your nurses' association, is essential to the profession. It's part of our ethics. The ANA Code of Ethics even states that *"the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient."*

And for nurses who can't spend a day in a committee meeting or travel to lobby legislators your membership in KNA and ANA is a powerful way to advocate for your profession. With lower dues, many more nurses have taken advantage of all the benefits that KNA and ANA offer.

If you believe in supporting KNA efforts to advance health care and protect nurses, add your voice and support by becoming a member. Membership dues for joint membership in KNA and ANA are an affordable $11/month or $126/year. Membership includes a free monthly Navigate Nursing webinar, a subscription to *The American Nurse* and *American Nurse Today,* savings on education programs, networking opportunities and more.

The Human Touch

The Human Touch by Marg

THE PAINTING

"The Human Touch" is an original oil painting 12" x 16" on canvas which was the titled painting of Marge's first art exhibit honoring colleagues in nursing. Prompted by many requests from nurses and others, she published a limited edition of full color prints. These may be obtained from the Kentucky Nurses Association.

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The Human Touch

Her step is heavy
Her spirit is high
Her gait is slow
Her breath is quick
Her stature is small
Her heart is big.
She is an old woman
At the end of her life
She needs support and strength
From another.

The other woman offers her hand
She supports her arm
She walks at her pace
She listens intently
She looks at her face.
She is a young woman at the
Beginning of her life,
But she is already an expert in caring.

RN Poet
Beckie Stewart*

*I wrote this poem to describe the painting, ***The Human Touch*** by Marge."
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KNA Members on the Move

Donna Blackburn, PhD, RN, Professor of Nursing at Western Kentucky University retired July 1, 2014. Her nursing career spans 44 years with the last 28 years in nursing education at WKU. She has taught in the associate, baccalaureate, and graduate programs and also served as Department Head of Nursing for 8 years. Donna will continue teaching half time for the next 5 years through the University's Transitional Retirement Program. Congratulations, Donna!

Ellen Hahn, PhD, RN, FAAN, University of Kentucky College of Nursing, has been appointed as one of 12 ambassadors for the Friends of the National Institute of Nursing Research, an independent non-profit group advocating for nursing science on behalf of the National Institute of Nursing Research (NINR). The inaugural group of ambassadors consists of nursing and health care leaders who possess stellar research, leadership and communication skills. These individuals will foster political, social, and professional awareness of the work of NINR and its research priorities.

Among the group's goals are educating congressional leaders and others within their respective communities, and advocating for improved funding by highlighting the impact nursing research has on the health and well-being of all Americans.

Marianne H. Hutti, PhD, WHNP-BC, University of Louisville College of Nursing, received 1st Place – "Research Study Paper Award" – for her presentation of "The Continuing Psychometric Evaluation of the Perinatal Grief Intensity Scale in the Subsequent Pregnancy after Perinatal Loss", 2014 national meeting of the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), June 13, 2014, Orlando, Florida. Deborah Armstrong, PhD, RN and John Myers, PhD, MPH, were co-Investigators.

Congratulations to **Susan Frazier, PhD, RN, FAHA,** and PhD student Allison Jones, MSN, RN, both of the University of Kentucky College of Nursing, for a recent $6,000 award for their study, "Predictors of Cognitive Function and Disability in Adult Trauma Patients who Receive Blood Transfusions." The study, funded by the Emergency Nurses Association Foundation, will evaluate the association of blood transfusion volume, ratio of components and age of stored blood components with cognitive/psychological functioning in trauma patients.

Barbara Polivka, PhD, RN, presented a poster in April 2014 at the AORN Surgical Conference in Chicago, IL, entitled "Pain Experience for Adults Having IV Insertion With and Without Use of Needleless Local Anesthetic Injection System."

Barbara Polivka, PhD, RN, also presented a paper at the 38th annual Midwest Nursing Research Conference in St. Louis, MO, "The meaning, experiences, and behaviors of nurses caring for women with a fetal loss."

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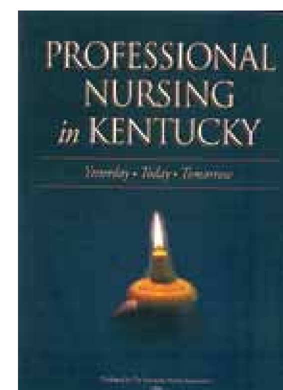

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The College of Nursing invites applications for the position of Coordinator of the Doctor of Nursing Practice (DNP) degree program. The DNP Coordinator will assume leadership for recruitment, curriculum oversight, and program evaluation. The successful candidate will also have major responsibility for overseeing and teaching program offerings. In addition, the coordinator will organize, and evaluate courses and clinical experiences for nursing students, in collaboration with other nursing faculty members. The Coordinator will report to the Associate Dean for Graduate Programs, as well as the Dean.

Faculty responsibilities include: plan, implement, and evaluate nursing degree curriculum, participate in university and community service activities, satisfy committee appointments, and engage in professional activities. Teaching, scholarship, and service are components of work expectations of faculty.
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- Prior academic experience required; prior full-time graduate online teaching experience preferred.

Preference will be given for candidates who are eligible for unencumbered licensure as an Advanced Practice RN in Georgia (family nurse practitioner preferred), as well as those with two years of experience in the Advanced Practice role and two years of experience as a DNP.

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