President’s Pen

Leadership, Labels And Forging Our Future

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!
Chapters Presidents and Treasurers - 2014

PRESIDENTS TREAURERS

RIVER CITY CHAPTER (1)
Carolyn Claxton, RN
421 Goodlard Avenue
Louisville, KY 40224-1543
E-Mail: CarolynClaxton4@yahoo.com
H: 502-749-7455
Paula F. Adams, EdD, RN
3047 Crystal Waters Way
Louisville, KY 40299-4897
E-Mail: pfadam01@louisville.edu
H: 502-267-4372
BLUEGRASS CHAPTER (2)
Laura D. Redle, MSN, RN, C
603 Fishers Mill Road
Midway, KY 40347-9750
E-Mail: bdredl2@gmail.uky.edu
H: 859-846-4869
Nancy Garth, RN
3292 Sholes Lake Drive
Lexington, KY 40515
E-Mail: Nancy.Garth055@gmail.com
H: 859-323-0733
NORTHERN KENTUCKY CHAPTER (FORMERLY DISTRICT 3)
Deborah J. Faust, MSN, RN
2041 Strawflower Court
Independence, KY 41015
E-Mail: DJFaust11@gmail.com
H: 502-655-1961
Susan E. Nesmith, APRN, RN
135 Kincaid Lane
 Erlanger, KY 41018
E-Mail: ds_c@insightbb.com
H: 859-360-6814
HEARTLAND CHAPTER (FORMERLY DISTRICT 4)
Kathleen M. Ferriell, MSN, BSN, RN
8700 Fishers Mill Road
Independence, KY 41015
E-Mail: Kathleen.Ferriell@lpnt.net
H: 502-549-7455
Paulette F. Adams, EdD, RN
135 Kincaid Lane
 Erlanger, KY 41018
E-Mail: pfadam01@louisville.edu
H: 859-360-6814
WEST KENTUCKY CHAPTER (FORMERLY DISTRICT 5)
Carolyn Claxton, RN
248 Bowlie Avenue
Murray, KY 42071
E-Mail: CarolynClaxton64@yahoo.com
H: 603 Fishers Mill Road
Midway, KY 40347-9750
E-Mail: CarolynClaxton64@yahoo.com
H: 502-749-7455
Paulette F. Adams, EdD, RN
3047 Crystal Waters Way
Louisville, KY 40299-4897
E-Mail: pfadam01@louisville.edu
H: 502-267-4372
KENTUCKY NURSE REACH – RESEARCH, EDUCATE, ADVOCATE, CARE, HELP (FORMERLY DISTRICT 7)
Kathy L. Hall, MSN, BSN, RN
300 Covington Avenue
Springfield, KY 40069
E-Mail: kmaragnor@kctcs.edu
H: 859-336-5938
Liz Sturgeon, MSN, RN
2741 Avendale Drive
Bowling Green, KY 42104
E-Mail: lis.strugonr@kctcs.edu
H: 270-762-6669
KENTUCKY NURSES REACH – RESEARCH, EDUCATE, ADVOCATE, CARE, HELP (FORMERLY DISTRICT 7)
Kathy L. Hall, MSN, BSN, RN
300 Covington Avenue
Springfield, KY 40069
E-Mail: kmaragnor@kctcs.edu
H: 859-336-5938
Liz Sturgeon, MSN, RN
2741 Avendale Drive
Bowling Green, KY 42104
E-Mail: lis.strugonr@kctcs.edu
H: 270-762-6669
NIGHTINGALE CHAPTER (FORMERLY DISTRICT 9)
Nancy Armstrong, MSN, RN
1881 Furches Trail
Murray, KY 42071
E-Mail: NancyArmstrong@kctcs.edu
H: 859-345-4466
Carol Murch, APRN, MSN
18143 Upper Delaware Road
Henderson, KY 42420
E-Mail: carol.murch@kctcs.edu
H: 270-831-9787
Lorraine B. Borman, RN
693 Porter School House Road
Bowling Green, KY 42101
E-Mail: lormannbo@kctcs.edu
H: 270-745-2718
Kathy Garth, PhD, RN
7274 Avendale Drive
Bowling Green, KY 42104
E-Mail: kathy.garth@murraystate.edu
H: 270-762-6669
NORTHWESTERN CHAPTER
Mary Jo Cornett, MSN, RN
1181 Pimble Road
Murray, KY 42071
E-Mail: MaryJoCornett@kctcs.edu
H: 270-521-9980
Joyce E. Vaughn, BSN, RN
1881 Furches Trail
Murray, KY 42071
E-Mail: Joyce.E.Vaughn@kctcs.edu
H: 270-831-9787

Information for Authors

• Kentucky Nurse Editorial Board welcomes submission articles to be reviewed and considered for publication in Kentucky Nurse.
• Articles may be submitted in one of three categories:
  • Personal opinion/experience, anecdotal (Editorial Review)
  • Research/scholarship/clinical/professional issue (Class A Peer Review)
  • Research Review (Editorial Review)
• All articles, except research abstracts, must be accompanied by a signed Kentucky Nurse transfer of copyright form (available from KNA office or on website www.Kentucky-Nurses.org) when submitted for review.
• Articles will be reviewed only if accompanied by the signed transfer of copyright form and will be considered for publication on condition that they are submitted solely to the Kentucky Nurse.
• Articles should be typewritten with double spacing on one side of 8 1/2 x 11 inch white paper and submitted in triplicate. Maximum length is five (5) typewritten pages.
• Articles should also be submitted on a CD in Microsoft Word or electronically.
• Articles should include a cover page with the author’s name(s), title(s), affiliation(s), and complete address.
• Style must conform to the Publication Manual of the APA, 6th edition.
• Monetary payment is not provided for articles.
• Receipt of articles will be acknowledged by a letter to the author(s). Following review, the author(s) will be notified of acceptance or rejection. Manuscripts that are not used will be returned if accompanied by a self-addressed stamped envelope.
• The Kentucky Nurse editors reserve the right to make final editorial changes to meet publication deadlines.

• Articles should be mailed, faxed or emailed to:
  • Articles may be submitted in one of three categories:
  • Personal opinion/experience, anecdotal (Editorial Review)
  • Research/scholarship/clinical/professional issue (Class A Peer Review)
  • Research Review (Editorial Review)
• All articles, except research abstracts, must be accompanied by a signed Kentucky Nurse transfer of copyright form (available from KNA office or on website www.Kentucky-Nurses.org) when submitted for review.
• Articles will be reviewed only if accompanied by the signed transfer of copyright form and will be considered for publication on condition that they are submitted solely to the Kentucky Nurse.
• Articles should be typewritten with double spacing on one side of 8 1/2 x 11 inch white paper and submitted in triplicate. Maximum length is five (5) typewritten pages.
• Articles should also be submitted on a CD in Microsoft Word or electronically.
• Articles should include a cover page with the author’s name(s), title(s), affiliation(s), and complete address.
• Style must conform to the Publication Manual of the APA, 6th edition.
• Monetary payment is not provided for articles.
• Receipt of articles will be acknowledged by a letter to the author(s). Following review, the author(s) will be notified of acceptance or rejection. Manuscripts that are not used will be returned if accompanied by a self-addressed stamped envelope.
• The Kentucky Nurse editors reserve the right to make final editorial changes to meet publication deadlines.

Editors, Kentucky Nurse Kentucky Nurses Association, P.O. Box 2616, Louisville, KY 40201-2616
(502) 637-2546 • Fax (502) 637-8236 • or email: CarleneG@Kentucky-Nurses.org

Earn a Credential
That’s in Demand Nationwide
• “Top 5” ranking in nursing school
• Practice specialties for all settings
• State-specific career info and facilities
• Community of scholars with broad nursing service
• Distance learning opportunities
• Seamless BSN entry–
MSA-JNP option

LEARN MORE, APPLY TODAY
nurseonet.org

Published by: Arthur L. Davis Publishing Agency, Inc.
DATA BITS

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

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

While it is very likely you have visited the Emergency Department (ED) of a hospital and experienced frustration at long wait times and crowding, 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 EDs. 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 2008 [admitted after the 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 2008 [admitted after the implementation of an LMP (2008 vs. 2009). Data were selected for the control group (LMP)], while the control group (IPLOS) was comprised of patients admitted during 2008. 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.


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.
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 presence 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, & Mechertkunnel, 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 potential 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. The majority of evidence reports significant staff concerns about family presence during CPR and less concern about any potential negative consequences.

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, Devetor, & Norekval, 2008; Itzhaki, Bar-Tal, & Barnoy, 2009; de Graaf, Lynch, Devetor, & Norekval, 2008; Itzhaki, Bar-Tal, & Barnoy, 2009; Jaher, Belpomme, Azoulay, Jacob, Bertrand, Lapostolle, & Tazarourte, 2013; Jones, et al., 2011; Leung, & Chow, 2012; Lowry, 2012; Meert, Clark, & Eggly, 2013; Sheng, Lim, & Rushih, 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 providers during resuscitation, and subsequently, have concerns that family members may be more apt to sue the hospital and the health care team members (Jones, et al., 2011; Downer & Kritek, 2013; Fell, 2009; Itzhaki, et al., 2012; Jaher, 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 (Jones, et al., 2011; Meert, et al., 2013). This stress caused 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 the staff is focused on the family 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, minor stressors may be unique to the positive effect on families (Jaher, 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 personnel caring for 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 potentiately 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 room staff. Family presence can be beneficial because it is helpful with translating, providing information to the nursing and emergency room staff. Family presence can be beneficial because it is helpful with translating, providing information to the nursing and emergency room staff.
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 & Krzik, 2013; Fell, 2009; Jones, et al., 2011; Lowry, 2012). By increasing 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. Erroesoneous 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.

References


You’ve always dreamed of being a nurse. Now find your dream job at nursingALD.com

Dynamic Career Opportunity

Mildred Mitchell-Bateman Hospital is a 110-bed Acute Care Mental Health facility operated by the West Virginia Department of Health & Human Resources. We are seeking qualified staff to fill permanent and temporary positions:

• Staff RNs • LPNs • Health Service Workers • Interpreters

Some of the benefits you will enjoy:

You enjoy state paid holidays with incentive for working Thanksgiving, Christmas, and New Year's Day.

Accredited Sick Leave

Accredited Annual Leave

Shift differential for evenings and night shifts

Education Assistance (Tuition Reimbursement)

Anniversary pay after 3 years of service

Employee Retirement System

Comprehensive Health insurance plans, including PEOA

Prescription Drug Plan and optional dental and vision coverage

Staff to staff

Temporary positions do not include benefits. Interested individuals should contact:

Patricia G. Hamilton, RN, BC Director of Nursing

1530 Norway Avenue, Huntington, WV 25709

Phone 304-525-7801 X 734  •  FAX 529-6399

You’ve always dreamed of being a nurse. Now find your dream job at nursingALD.com

Free to Nurses!
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, Retter, Blaer, & 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*, antenatal, 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 confounding variables. The severity and duration of anxiety are associated with a shorter gestation and often implicated high risk for preterm birth (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 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).
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 involving partners of the woman may be individual and include going out with friends, relying on spiritual support, and talking to a therapist or other expert. Research suggests that social support during pregnancy is associated with better birth outcomes (Dunkel Schetter, 2011).

A combination 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. Psychologic 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 for childbearing women significantly associated with lower anxiety in pregnant women. Implementation of group care or participation in Centering Pregnancy may help identify women at risk for experiencing pregnancy anxiety and carry out interventions more effectively. Centering Pregnancy 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, Centering Pregnancy expands upon the birth experience by including classes on health habits, self-esteem and satisfaction, stress management, and anxiety reduction (Walker & Worrell, 2008).

Pregnancy can 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 (2010) suggests that a mood disturbance may have 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) levels have been shown to differ between anxiety and preterm birth (Kramer et al., 2009). One study found a positive correlation between an elevated level of maternal CRH and pregnancy-related anxiety. Anxiety has been found to cause changes in maternal and fetal levels, and anxiety levels, and 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 mechanism of this relationship to be understood.

Anxiety in pregnancy is a significant problem that has been shown to increase the risk of experiencing preterm birth. Though there are many identified factors of 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 section may be submitted electronically to her at donna.blackburn@wku.edu.

References

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

Frontier Nursing University (FNU) is celebrating 75 years of providing nurses to become midwives and nurse practitioners. Many midwives and nurse practitioners that have been involved in the care of public health nursing and midwifery-in which she saw as an answer to decreasing maternal mortality and underdeveloped healthcare in rural America—have been dedicated to the children in rural areas and she started the Frontier Nursing Service. In 1939, in her book Who Needs Midwives? Mrs. Breckinridge states, “...for women should begin before they are born, should carry them through their greatest hazard which is childbirth and would be the most intimate during their first six years of life. These are the formative years, the years in which they learn to shape their habits, 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 midwives who had helped create FNS were leaving to support the war effort and Mrs. Breckinridge knew that 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 maternal 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) to reflect the growth and development of the school.

The legacy of Mrs. Breckinridge continues today through the graduates of Frontier Nursing University from all over the country travel to Kentucky to begin their education as nurse-midwives and nurse practitioners. Students at FNU have a commitment to improve healthcare for the mothers, babies, and families in their communities. The Frontier Nursing University campus for orientation builds a community of learners through an understanding of the legacy of Mrs. Breckinridge 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 online education and has been providing education at a distance since 1988. Students at FNU are engaged in learning with each other and their learning 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 practice to apply their knowledge to care for mothers, babies and families in their home communities. Students completing their doctoral education have the opportunity to work with content experts that deepen their knowledge of their particular area of interest in the following specialties:

• Doctor of Nursing Practice
• Women’s Health Care
• Nurse-Midwife
• Nurse Practitioner

FNU offers degrees for registered nurses (RNs) to complete the requirements 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-midwife, family nurse practitioner or women’s health care nurse practitioners specialists.

Throughout the past 75 years, FNU has evolved from a school to a premier nursing university that educates students to become nurse-midwives and nurse practitioners to improve healthcare in their communities. The Frontier Nursing University (FNU) student live in rural or underserved areas. There are nearly 4,000 nurses that graduate from Frontier Nursing University in 75 years and nurse practitioners that demonstrate daily the commitment Mrs. Breckinridge had to improving health outcomes and provides access to health care for mothers, babies and families. FNU proudly celebrates the legacy of Mary Breckinridge in all we do and aims to care for mothers, children, and families in rural areas and “wide neighborhoods of man.”
Kentucky’s Improvement in Administering Tdap for Adolescents: The National Immunization Survey-Teen 2008-2012

John Myers, MSPH PhD
Associate Professor, Bioinformatics and Child and Adolescent Research Design and Support (CARDS)
University of Louisville School of Medicine
Louisville, KY

The Advisory Committee on Immunization Practices (ACIP), since 2005, has recommended that routine administration of Tetanus-diphteria 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 Tdap 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 72.2% - 75.3%) to 85.8% in 2012 (95% CI 87.7% - 89.3%), p<0.01. Among TCV recipients only, 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

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 (83.0% 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.

References

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

Cathy H. Abell, PhD, MSN, MS, RN, CNE
Associate Professor

Corresponding Author
Lori Janes, MSN, RN
Assistant Professor

Tonya Bragg-Underwood, MSN, APRN, CNE
Assistant Professor

Western Kentucky University
Bowling Green, KY 42101

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. The health fair students attended was a community service project that required students to 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 and wellness across the lifespan including educating individuals to adopt strategies to promote prevention and wellness across the lifespan. This 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 were 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 be held. Students worked together 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 topics such as parking and driving on the lot.

To encourage attendance at 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, heart disease, falls, 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 workplace 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 the population. The American Association of Colleges of Nursing (2008) identified nine essentials of baccalaureate education. This activity fosters essential number three, six, and seven as required for participation by current evidence of best practice. The value of interprofessional communication and collaboration is noted in essential six (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 lost productivity (Health and Human Services, n.d.). Providing education to individuals can result in healthier lifestyles which can aide in preventing many chronic illnesses 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 opportunity to incorporate faculty service with teaching. Faculty also served as role models for students who observed faculty interacting with others in the community and health education to a specific population in a non-traditional setting.

Future Plans
This demonstrated a successful way to provide a learning opportunity 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 the health fair at the work site 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.

References

University of the Cumberlands

RN to BSN Program
- $199 credit hour
- 100% online
- 36 credit hours
- Complete in as little as 12 months

Graduate Admissions 1-800-343-1609
www.ucumberlands.edu

Special online savings for special people.
You work hard, so we’ve set up an online store just for you and your company. Come by to check out our service discount, free shipping and other specials. sprint.com/stateofkentucky

Sprint
Customer Service Hotline
1-800-928-4838

Activ. Fee:

SDP

Discount for employees of State of Kentucky Healthcare Facilities

Sprint’s E911 Discount
Sprint offers E911 service at a discount to customers on Sprint’s Tier 1 network. E911 service is made available to Sprint’s Tier 1 customers. The discount is applied to the monthly recurring charge for your service. This discount is for emergency services (911 calls) only. This service is subject to change at any time. Other terms and conditions apply. Please contact Sprint for additional information. Sprint offers E911 service to all customers on Sprint’s Tier 1 network, including customers on refurnished equipment and where public safety networks are not available. This service is subject to change at any time. Other terms and conditions apply. Please contact Sprint for additional information.
Assessing the Home Fire Safety of Urban Older Adults: A Case Study

Stephanie Tywman, BA, Nursing Student, Second Degree Program
Erin Fahey, BS, BSN, RN, Program Coordinator
Cartea Lehna, PhD, APRN-BC, Associate Professor Investigator
University of Louisville, School of Nursing
Louisville, KY 40292

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 conducted 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 injury and death.

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

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 for home fire safety (HFS) that are compounded by age-related difficulties. Warda, Tenenbein, and Moffatt (1999) found that older adults had a higher risk for fire hazard exposure. 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, had two chronic illnesses, had fallen three times, and had an annual income below 125% of the poverty level. She had received 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 USFA Home Safety Checklist for older adults. HFS hazards were identified including non-working smoke alarms, cooking safety, candle safety, and smoking safety. Ms. Jones did not have a home fire escape plan. She did not know what a carbon monoxide (CO) alarm looked like. She had not replaced batteries. Ms. Jones did not have any smoke alarms. The only other smoke alarm, without working batteries, was located in the basement. Ms. Jones indicated that she did not know what a carbon monoxide (CO) alarm looked like.

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 fire safety and ability to increase her safety and decrease her risk of injury was limited. There was concern for her ability to set a smoke alarm; proper setting and care; the importance of smoke alarms and carbon monoxide alarms; proper placement of smoke alarms; and the importance of a home fire escape plan. She did not know to place the smoke alarm on the ceiling, away from the bedroom door, or the stove. She did not know how to operate a smoke alarm. She did not know how to check the battery. She did not know how to test the smoke alarm. She did not know what an alarm sounded like. She did not know how to respond to a smoke alarm.

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 no higher than 120°F. The hot water heater in the home of Mrs. Jones was set at 132°F. A flooded bathroom floor and stove was noted. Ms. Jones indicated that the stove had been flooding once a month. Ms. Jones indicated that she did not know what a carbon monoxide (CO) alarm looked like. She had not replaced batteries. Ms. Jones did not have any smoke alarms. 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. She was unclear as to where the alarm was located. She indicated that she did not know where the alarm was located. She did not know what a carbon monoxide (CO) alarm sounded like. She did not know how to operate a smoke alarm. She did not know how to check the battery. She did not know how to test the smoke alarm. She did not know what an alarm sounded like. She did not know how to respond to a smoke alarm.

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 no higher than 120°F. The hot water heater in the home of Mrs. Jones was set at 132°F. A flooded bathroom floor and stove was noted. Ms. Jones indicated that the stove had been flooding once a month. Ms. Jones indicated that she did not know what a carbon monoxide (CO) alarm looked like. She had not replaced batteries. Ms. Jones did not have any smoke alarms. 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. She was unclear as to where the alarm was located. She indicated that she did not know where the alarm was located. She did not know what a carbon monoxide (CO) alarm sounded like. She did not know how to operate a smoke alarm. She did not know how to check the battery. She did not know how to test the smoke alarm. She did not know what an alarm sounded like. She did not know how to respond to a smoke alarm.

Conclusion
Older adults lack of HFS preparedness is an unreported 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 and cognitive impairments, learning ability, and living conditions.

Educational instruments and teaching efforts should also 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 address HFS behavior.

References

ACKNOWLEDGMENT
This study was funded by Federal Emergency Management Agency Fire Prevention & Safety Grant #EMW-2012-FP-01181 awarded to Dr. Lehna.
October 2014
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 KNA District 2@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

*All members are invited to attend KNA Board of Directors meetings (please call KNA first to assure seating, meeting location, time and date)

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 Knxley 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

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

January 2016
1 New Year’s Day Holiday – KNA Office Closed

*All members are invited to attend KNA Board of Directors meetings (please call KNA first to assure seating, meeting location, time and date)

Compassion Counts.

Compassion has to be taught by example. At Spencerian College, we ensure our graduates have the knowledge - and the empathy - to make a difference in the lives of their patients.

If you are looking for an emotionally rewarding career, consider nursing. Spencerian has helped hundreds of aspiring healthcare workers become licensed practical nurses (LPNs) and registered nurses (RNs).
Welcome New Members

The Kentucky Nurses Association welcomes the following new and/or reinstated members since the July / August / September 2014 issue of the Kentucky Nurse.

Sonya Absher
Rebecca Aker
Lori Alexander
Theodora Aliu
Bobette Andrikos
Tara Applegate
Rita Bailey
Tammy Bailey
Tina Baker
Catherine Bates
Kaye Bergman
Sharon Bibro
Nell B. Blankenship
Carol Bolling
Colleen Bond
Jessica L. Bowling
Colleen Bond
Samantha Bowman
Carol Bradford
Dreama Brannock
Karen Bridges
Michelle Brooks
Debbie Sue Brown
Amanda Burgan
Sonya Burke
Jayme Byrd
Elizabeth Cain
Molly B. Carew
Brandy A. Carlson
Nina Case
Ashley Castillo
Diane Chlebowy
Teresa Cobb
Lauren Cole
Kristen Danielle Combs
Pamela Coney
Andy Crawford
Karen J. Crump
Michael Curran
Amber Curry
Sandra Daniel
Shirley Davidson
Dulce Davis
Julie R. Duffy
Norma Delaney
Dean Douglas
Jo A. Elbert
Deborah Engel
Carol Ann Deyer
Sharon Edwards
Carrie Jean Epperson
Melissa Kay Fitzpatrick
Lynsey Renee Flynn
Kyle Fortune
Christina Foushe
Stephanie Franklin
Jennifer Fritz
Kathleen Gahlart
Cindy Gabriel
Tammy Gambril
Danny Garrett
Andrea Gay
Deborah Genovese
Andrea Gifford
Judi Godsey
SUSAN Goedlner
Amy Gootee
Cheryl Gore
Amanda Gregory
Celeste Hardesty
Daphne Hardesty
Susan Elizabeth Harper
Laura Hadden
Heather Mara Hagedorn
Mary Darleen Heist
Melissa Hershey
Audrie Hinson
Christie Hobson
Yolanda Lynn Hobscow
Lindsey Horrell
Christy Hubbard
Lesley Hubbard-Kriels
Cheleffs Jeffries
Karen Jennings
Brenda H. Johnson
Susan A. Jones
Tosia Jordan
Joni Keith
Monica Kincad
Heather King
Christopher Knoop
Betty Kuiper
Noemi Lane
Kelly Levoy
Casie Lewis
Susan J. Lewis
Sondra Lindsey
Tabeitha Loan
Johnnie Lovins
Brittney Lynch
Donna Lynch
Jassan G. Mailory
Anna Marie Marble
L. Beth Martin
Joann Mattingly
Kevin McCullum
Barbara Meseres
Brian Lee Merrick
Maegan Metcalfe
Terry Mckler
KELLY L. Mckles
Donna Miller
Gayle Mink
Susanna Moberly
Antalyan Marie Morgan
Kasey Murphy
Christine Myers
Beatrice K. Newton
Elizabeth Northcutt
Kathy D. O'Brien
Linda O'Byran
Herodina Orgella
Julianne Ossege
Patricia McGinn Passquarell
Kelly Pearl
Sara Perdue
Natalie Peterson
Beverly Phelps
Noel Pinson
Debra Jean Pizzuli
Amy Price
Jill Price
Jessica Rashid
Lori Rawlings
Lois Reed
Rebecca E. Renfroe
Caitlin Rhodes
Jennifer L. Rivera
Christine Romanis
Ayme Jo Rowland
Jesse Scheller
Jodie Sharp
Danelle Sherpman
Stefanie Danielle Shepherd
Pauline R. Siders
Jamie Simpson
Karen C. Stephens
Amber L. Tarpley
Faith Tingle
Jamie Tobelman
Carol J. Turley
Crystal Vance
Jennifer Vandiver
Whitney Van Vactor
Sally Vaughn
Jaime Walker
Julie Wallace
Shelia Washburn
Christopher Weber
Ashley Weiselt
Lesley White
Regina Wieger
Nina Voes Wilson
Melissa Woosley
Leslie Yocom
Jacquelyn E. Young
Robin G. Zachary
Beverly L. Zanewicz

Human Touch Collection: EMPATHY

"EMPATHY" is a fine jewelry signature piece of the Human Touch Jewelry Collection. The name conveys caring, compassion, empathy and a desire to understand the needs of others. The collection is dedicated to the role of the nurse in an ever-changing world, acknowledging the difficult times nurses face and celebrating all the hard work nurses do.

Can be worn as a Pin or a Pendant. There are three options available to choose from:

Option 1 Option 2
Sterling silver $77.00 $10.60 $87.60
14K gold pendant over Sterling Silver $110.60 $22.00 $132.60
Sterling silver with a 14K gold heart $175.00 $37.20

Shipping and Handling:
- $0.01 - $30.00: $6.50
- $30.01 - $60.00: $8.00
- $60.01 - $200.00: $10.95
- $200.01 and up: $14.00

Expiry Date: __________ CIV: __________

Subtotal $58.22 $79.58 $137.70
Shipping and Handling $6.50 $8.00 $14.50
TOTAL $64.72 $87.58 $152.10

Credit Card: __ Visa __ Mastercard __ Discover __ American Express

Shipping and Handling: $0.01 - $30.00…...$6.50 $60.01 - $200.00…...$10.95 $200.01 and up………$14.50

For more information, contact KNA at (502) 637-2546.

Photo submitted by the Kentucky Nurses Association, July 2005 to the Citizens Stamp Advisory Committee requesting that a first class stamp be issued honoring the nursing profession. (Request Pending)

"NURSING: LIGHT OF HOPE"

by Scott Gilbertson
Folio Studio, Louisville, Kentucky

Package of 5 Note Cards with Envelopes - $5 for $6.50

Make check payable to and send order to: Kentucky Nurses Association, P.O. Box 2616, Louisville, KY 40201-2616 or fax order with credit card payment information to (502) 637-8236 or email to CarleneG@Kentucky-Nurses.org. For more information, please call (502) 637-2546.

Name: __________________________ Phone: __________________________
Address: ________________________
City: ____________________________ State: __________ Zip Code: ________
Visa/MasterCard/Discover/American Express: __________________________

Signature (Required for Credit Card Orders): __________________________
Expiration Date: __________ CIV: __________

Shipping and Handling: $0.01 - $30.00…...$6.50 $60.01 - $200.00…...$10.95 $200.01 and up………$14.50

Express Delivery will be charged at cost and will be charged to a credit card after the shipment is sent.
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.

Go to www.joinana.org to become a member and use the code: KNA2013

We have a long history of representing nursing professionals who are licensed by the Commonwealth of Kentucky and experience a claim that could result in either a loss of license or professional discipline.

1974-A Douglass Boulevard, Suite 100
Louisville, KY 40205
502.425.7774 phone
www.RandSLaw.net

Carmel Manor

“Six Decades of Loving Care!”

We offer Personal, Skilled Care and Rehab Services.

Located just outside of Cincinnati—we have a beautiful location overlooking the Ohio River.

Serving the Northern Kentucky/Cincinnati area.

Carmel Manor is a 145-bed nursing facility—looking for RNs for a “long-term” commitment.

Schedule a visit with us—you will feel the difference!!

Carmel Manor Rd. 859-781-5111
Ft. Thomas, KY

When disaster strikes, who will respond?

The Kentucky Department for Public Health is seeking nurses to register and train as Medical Reserve Corps (MRC) volunteers. When events such as ice storms, flooding or pandemics occur in Kentucky, our citizens need nurses to provide compassionate care. Register to volunteer and receive training from your local MRC unit today. By doing so, you can be prepared to serve your community, family and neighbors when they need it most.

To learn more, go online at www.kentuckyhelps.com
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 $81/month or $9816/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 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.

Copyright 1980
Limited Edition Prints by Marjorie Glaser Bindner, RN Artist
Limited Edition Full Color Print, Overall size 14 x 18
Signed and numbered (750)—SOLD OUT, Signed Only (1,250)—$20.00
Note Cards—5 per package for $6.50

Shipping and Handling

TOTAL

FOR MAIL OR FAX ORDERS
I would like to order an art print of “The Human Touch”©

Make check payable to and send order to: Kentucky Nurses Association, P.O. Box 2616, Louisville, KY 40201-2616
or fax order with credit card payment information to (502) 637-8236 or email to carleneg@kentucky-nurses.org.

Shipping and Handling

*Express delivery will be charged at cost and will be charged to a credit card after the shipment is sent.

FOR PHONE ORDERS

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.
Edmonds, Washington 1994

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.

Copyright 1980
Limited Edition Prints by Marjorie Glaser Bindner, RN Artist
Limited Edition Full Color Print, Overall size 14 x 18
Signed and numbered (750)—SOLD OUT, Signed Only (1,250)—$20.00
Note Cards—5 per package for $6.50

Shipping and Handling

TOTAL

FOR MAIL OR FAX ORDERS
I would like to order an art print of “The Human Touch”©

Make check payable to and send order to: Kentucky Nurses Association, P.O. Box 2616, Louisville, KY 40201-2616
or fax order with credit card payment information to (502) 637-8236 or email to carleneg@kentucky-nurses.org.

Shipping and Handling

*Express delivery will be charged at cost and will be charged to a credit card after the shipment is sent.

FOR PHONE ORDERS
Professional Nursing in Kentucky * Yesterday * Today Tomorrow


Gratitude is expressed to Donors whose names will appear in the book’s list of Contributors. Their gifts have enabled us to offer this limited edition hard-back coffee-table-type book at Below Publication Cost for Advance Purchase Orders.

The Editors have collected pictures, documents, articles, and stories of nurses, nursing schools, hospitals, and health agencies to tell the story of Professional Nursing in Kentucky from 1906 to the present.

Name ____________________________________________
Address ____________________________________________
City_________ State____ Zip_________
Credit Card Payment (Circle One):
MasterCard – Visa – Discover - American Express
Number ____________________________ CIV _________
Exp. Date ________________ Signature ___________
Fax, Mail or E-mail Order to:
Kentucky Nurses Association
P.O. Box 2616, Louisville, KY 40201-2616
FAX: 502-637-8236
E-mail: carleneg@kentucky-nurses.org

Special Price - $18.87 Per Book
____ $18.87 per book
____ $1.13 sales tax per book
____ Add $6.50 shipping and handling per book
____ (for 1-5 books - $10 or 6-19 books $20)
____ Total Purchase
____ Grand Total

Regional accrediting agencies

Sullivan University is accredited by the Southern Association of Colleges and Schools Commission on Colleges to award associate, baccalaureate, master’s and doctoral degrees. Contact the Commission on Colleges at 1866 Southern Lane, Decatur, Georgia 30033-4097 or call 404.679.4500 for questions about the accreditation of Sullivan University. The baccalaureate Nursing program at Sullivan University is accredited by the Commission on Collegiate Nursing Education (http://www.aacn.nche.edu/ccne-accreditation). For more information about program successes in graduation rates, placement rates and occupations, please visit sullivan.edu/programsuccess.

sullivan.edu/mybsn
Founded in 1902 as a school of nursing, the Georgia Baptist College of Nursing is the oldest nursing program in Georgia. Over its 111-year history, the College has graduated more than 7,350 nurses. Since its founding, the College remains dedicated to educating the person, fostering the passion and shaping the future of nursing. The College merged with Mercer University in 2001 and offers the following degrees: Bachelor of Science in Nursing, a Master of Science in Nursing, a Doctor of Nursing Practice and a Ph.D. in nursing. The College of Nursing is one of four academic units within the Mercer University Health Sciences Center.

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 components of work expectations of faculty. The successful candidate is required to have:
- An earned doctoral degree in nursing from an accredited college/university
- An unencumbered Georgia Registered Nurse license
- 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.

This position will be on the Mercer University Atlanta Campus.

Applicants must complete the brief online application at https://www.mercerjobs.com and attach 1) a curriculum vitae, 2) a statement of research/scholarship interests and professional goals, 3) a statement of teaching philosophy, and 4) the names and addresses of three references. Review of applications will continue until the position is filled. ADA/EEO/Veteran/Disability

www.mercer.edu

UK HealthCare.

Reach your full potential at Kentucky’s leading health care center.

The chance to make a significant and lasting difference in the lives of patients and families—

it’s why you became a nurse in the first place. At UK HealthCare, you’ll join others, like yourself,

with a shared vision and values to practice innovative, compassionate care in an atmosphere of true

collaboration—and in a setting second to none. Our new, state-of-the-art patient care facility has

openings for the Commonwealth’s top nurses with salaries and benefits that reflect the high

caliber of nursing professionals we seek. Could you be one of them?

CURRENTLY RECRUITING FULL TIME RNs FOR THE FOLLOWING AREAS:

- OB/GYN
- Pediatrics
- Orthopedics
- Neurosurgery
- Trauma
- Critical Care
- Emergency Department
- Wound Care
- Oncology
- Med-Surg/ICU
- Cardiovascular
- Specialty Areas

Reach your full potential at Kentucky’s leading health care center.

You were meant for this.

UK College of Nursing

Work for UK HealthCare and enjoy all the benefits!

THE COLLEGE OF NURSING OFFERS:

- RN-BSN
- RN-BSN
- MSN-DNP
- BSN-PhD
- MSN

DNP tracks include: Adult-Gerontology Acute Care Nurse Practitioner | Adult-Gerontology Clinical Nurse Specialist | Family Nurse Practitioner | Neurovascular | Oncology | Obstetrics/Gynecology | Population Health | Psychiatric/Mental Health Nurse Practitioner | Wound Care Nurse Practitioner

www.uknursing.uky.edu