from the President...

by Holly Decker-Carlson, MS, RN, CCRN
Email: president@idahonurses.org

I want to start by congratulating EVERY nurse for your individual contribution towards building and maintaining the public's trust with your unwavering professionalism. It is not a surprise that nurses are nationwide examples and leaders of sound ethics. In addition to being honest, nurses personally care about every patient and this will always place us at the top! Thank you for all you do each day with every patient you encounter!

Knobs or a Remote?
Big bulky box versus a flat screen. I think you all recognize what I am talking about: TV’s. I would venture a guess that very few reading this have a TV without a remote. A remote provides you with advanced technology that allows you to stay where you are and change channels, adjust volume, and start your DVD player; some may even surf the internet. I am fairly confident that when your battery dies and you no longer have the convenience of a remote, there is at minimum an irritated sigh as the journey begins to either manually operate the TV or look for replacement batteries. I also believe that among many of us there are fond memories of a large TV with knobs that would rotate and rifle through six or seven channels—you know, the knob you would take so no one else could change the channel. And now we have the remote. A tool that evolves every year to keep up with the latest TV technology, a piece of technology I find intimidating and, at times, excessive and unnecessary. You are probably asking yourself why I would find it intimidating. I find it intimidating because I don’t want to take the time to educate myself on how to operate it, the TV, the satellite box, and most definitely not the DVD player. I pay more than $100 a month for entertainment I don’t know how to use—not wise on my part.

My issue with my TV and all of its accessories is not any different than nurses’ lack of interest in professional development. Our industry mantra is if you passed the boards once and you complete the annual competencies for your specific organization, then you are deemed current. This is short-sighted on our part. We are forced into updating our knowledge with bare minimum practice standards as those standards are becoming obsolete. They are becoming obsolete because we as a profession are so resistant to seeking current information and integrating the knowledge on our own. We wait until someone develops a module and forces a practice change on us before we integrate it into our care.

Think about the honor of being rated as the most ethical profession in the nation. Now ask yourself, are we as knowledgeable as we could be? Every nurse goes to work with the intent to be the best nurse they can be, but are we? Are we champions for innovative practice standards? Do we seek out opportunities to develop our profession? Do we invest in our own professional development? I believe that if we as individual nurses do not regularly invest in our professional knowledge and growth, we aren’t the best nurse that we can be for our patients, co-workers, and organizations.

From the President continued on page 2

A Change in the INA Executive Director

On behalf of the INA board, we would like to thank Regina Robuck and the Meeting Expectations Company for the association leadership and support they have provided to INA. INA was in a difficult position when Meeting Expectations began and the company has literally revived and stabilized our association.

That being said, we are moving our Executive Directorship to the leader of the ANA Multistate Division Executive Director, Robin Schaeffer. Robin brings a tremendous amount of experience in association management as well as health care. Robin is a nurse and has great plans to accelerate our association’s growth and to diversify the opportunities for INA. See Robin’s biography in this issue of RN Idaho on page 3.

Again, thank you, Regina and Meeting Expectations; we are forever grateful!

Sincerely,
Holly Carlson, INA President

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I have been there, thinking, “I go to work, I do my job, and I go home. I don’t want to do any more, that is my time.” This is okay if you want to continue to be forced into change. I would like to share with you the day that I quit being forced into change; it was the last semester of my master’s degree. My degree is a business degree. One of the reasons I decided to go for a business degree was force. This is okay if you want to continue to be forced into change with licensure legislation that requires nurses to do a scant amount of professional development in 15 years. Why does it take a master’s degree to jump-start personal investment into the nursing profession—a profession that works to heal millions in need of care and will support the nurse and her or his family for many years? Shouldn’t nurses commit to professional development from the beginning of their careers? Why are we waiting to be forced into change with licensure legislation that requires nurses to do a scant amount of professional development in order to remain licensed? We have a choice and an awesome opportunity here: we can continue to be forced into change or we can collectively eliminate professional development avoidance and become the nation’s most invested and progressive profession.

I suspect remotes, just like knobs, will always be conveniently hidden; however, if you don’t know how to operate them, then hiding them does not serve a purpose.

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For information about manuscript format, submission of photographs, publication selection and rights, and advertising in RNI, please visit the INA website at http://www.idahonurses.org under “News/Links.” You may also contact the INA at rniidaho@idahonurses.org or by phone 1-888-721-8904.

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Update From The Idaho Board Of Nursing

by Sandra Evans, M.A.Ed., RN, Executive Director
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The 1st Regular Session of the 63rd Idaho Legislature will have convened by the time this issue of RN Idaho is published. As in previous years, the Idaho Board of Nursing (IBON) will be enthusiastic about the Session presenting pending administrative rules of the Board: defending the Board’s FY2016 budget request; monitoring bills that impact the Board as an agency of state government, and also impact the safety, health and welfare of patients and the public; responding to requests from policy makers for information and bill analysis as they maneuver through the complex task of lawmaking in the brief period of time they are in Boise doing “the work of the people.”

The Board is committed to allow for further discussion and refinement for possible rulemaking in 2016. The Board appreciates the many comments received from the nurse-patient relationship, and any information obtained as a result of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct directed at patients, former patients, colleagues, or members of the public, whether within or outside the workplace; Engaging in or soliciting any type of sexual conduct with a patient; Using the nurse-patient relationship, trust and confidence of the patient derived from the nurse-patient relationship, or any information obtained as a result of the nurse-patient relationship to solicit, suggest or discuss dating or a romantic relationship with a patient;

3) Provide further clarification of the statute, indicating:
   1) Define terms such as “sexual misconduct,” “sexual exploitation” and “criminal sexual misconduct”
   2) Identify behavior that constitutes sexual misconduct to include, but not limited to:

      a. Engaging in or soliciting any type of sexual conduct with a patient;
      b. Using the nurse-patient relationship, trust and confidence of the patient derived from the nurse-patient relationship, or any information obtained as a result of the nurse-patient relationship to solicit, suggest or discuss dating or a romantic relationship with a patient;
      c. Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct directed at patients, former patients, colleagues, or members of the public, whether within or outside the workplace; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct with a patient, former patient, colleague, or member of the public; and
      d. Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct directed at patients, former patients, colleagues, or members of the public, whether within or outside the workplace; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct directed at patients, former patients, colleagues, or members of the public, whether within or outside the workplace; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct directed at patients, former patients, colleagues, or members of the public, whether within or outside the workplace; Engaging in or attempting to engage in sexual exploitation or criminal sexual misconduct with a patient, former patient, colleague, or member of the public, unless the patient is determined by the

   3) Provide further clarification of the statute, indicating:
   Consent of a patient/victim to engage in sexual conduct;
   Engaging in or attempting to engage in sexual conduct with a patient, former patient, colleague, or member of the public, unless the patient is determined by the Board to be particularly vulnerable by his/her minority; known mental, emotional, or physical disability; known alcohol or drug dependency; or other circumstance. A patient that is deemed particularly vulnerable ceases to be a patient one year after receiving the final nursing services, or final reasonably anticipated nursing services from a nurse, unless the caring is determined by the Board to be particularly vulnerable by his/her minority; known mental, emotional, or physical disability; known alcohol or drug dependency; or other circumstance. A patient that is deemed particularly vulnerable ceases to be a patient one year after receiving the final nursing services, or final reasonably anticipated nursing services from a nurse.

   A second anticipated docket of rules that was to be presented this legislative session, Docket 23-0101-1402 related to Continued Competency, was withdrawn by the Board. Some comments received from the Board’s constituents at and prior to a public hearing held October 10th compelled the Board to withdraw the rules to allow for further discussion and refinement for possible rulemaking in 2016. The Board appreciates the many thoughtful comments and recommendations from nurses throughout the state that resulted in this timely decision.

   The nine-member, governor-appointed IBON meets quarterly to conduct its regular business related to strategic goals addressing 1) licensure, 2) practice, 3) discipline and alternatives to discipline, 4) education, 5) governance, 6) communication, and 7) organization. At their meeting held October 9–10, 2014, Board members:

   · Granted two RN licenses by endorsement based on substantial equivalence to Idaho’s licensure criteria;
   · Accepted revisions to existing policies related to nurse licensure;
   · Appointed Ronald Micali, MD, Twin Falls, to a 3-year term on the Advanced Practice Registered Nurse (APRN) Advisory Committee; and appointed Alissa Miller, RN, Coeur d’Alene, to a 3-year term on the Program for Recovering Nurses (PRN) Advisory Committee; and
   · Selected revised and reasonable revision of Board Mission, Vision and Values as the topic for the 2015 Board Business Retreat scheduled for May;
   · Considered two separate petitions ‘to change or adopt a rule’ and took action to investigate the requested rulemaking for consideration in 2016;
   · Accepted “Findings of Fact and Conclusions of Law” and revoked the licenses of two RNs and one LPN based on substantiated violations of the Nursing Practice Act and/or Rules of the Board;
   · Denied a “Petition for Reconsideration” of the October 2014 Board decision to revoke an RN license thereby upholding the original Order of Revocation;
   · Denied a “Petition for Reinstatement” of an RN license previously revoked by the Board and recommended that future consideration of licensure reinstatement be based on an objective psychological assessment of the individual’s propensity to reinstate in addition to any other requirements of the Board;

   · Accepted plans presented by BYU-Idaho to discontinue the current Associate Degree RN program and proposed curriculum changes to the Baccalaureate Degree RN program; accepted changes to the LPN program curriculum presented by the College of Southern Idaho;
   · Reviewed summaries of “2014 Annual Program Reports” for approved RN, LPN and APRN nursing education programs and approved nursing assistant training programs;
   · Reviewed draft revisions to Board philosophy statements on “Practice” and “Education” and provided feedback and further direction to the assigned committees; and

   · Continued discussion of Board member qualifications. Board members reviewed recent legislation enacted in Delaware that redefined member criteria thereby reducing the numbers of RNs, LPNs and consumers that will comprise the future Delaware Board of Nursing.

As always, the Board invites the public to attend scheduled Board meetings and participate in the Open Forum held on the second day of each meeting. The Open Forum provides the opportunity to dialogue with the Board on issues of interest that are not necessarily included on the published agenda. The Board will not take action on issues introduced during the Forum, but may choose to address them at a later scheduled Board meeting. The next meeting of the Board is tentatively scheduled for April 9–10, 2015, in Boise, at a location to be determined. For further information and a listing of IBON members, visit the Board’s Website at www.ibn.idaho.gov or contact Lyn Moore at lyn.moore@ibn.idaho.gov or 208.577.2500.

We Welcome Our New Executive Director: Robin Schaeffer, MSN, CNE, CAE

Thank you for the opportunity to serve as your Executive Director (ED) of ANA Idaho. As the current ED of the Arizona Nurses Association (AzNA) I will be using my leadership and operational skills to assure that ANA Idaho remains strategic and relevant in a healthcare environment that is rapidly changing. The model of one person functioning as ED over two states is being duplicated around the country. The skills set of running an association is something we do not learn in nursing school. In 2014 I achieved my Certified Association Executive (CAE) designation. The CAE program is accredited by the National Commission of Certifying Agencies and is designed to evaluate professional standards, enhance individual performance, and identify professionals who demonstrate the knowledge essential to the practice of association management.

Here is some additional information about myself; I have been a nurse for over 36 years with varied nursing career experiences including, but not limited to:

   · Tutored at Owyhee Community Health Facility.
   · Worked as ED over two states.
   · Worked as Executive Director of Arizona Nurses Association (AzNA). AzNA is a non-profit association. The work I perform and the care I provide is directed at patients, former patients, colleagues, or any information obtained as a result of the nurse-patient relationship to solicit, suggest or discuss dating or a romantic relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;
   · Using confidential information obtained during the course of the nurse-patient relationship to solicit, suggest or discuss a romantic or sexual relationship with a patient;

   · If you are not already a member of ANA Idaho, I encourage you to join. As the leading voice and advocate for the nursing profession in the State of Idaho, our membership and support will be worth every penny! Please visit http://www.idahonurses.org/.

Robin Schaeffer

Owyhee Community Health Facility

RN/LPN

Come join the health care team at OCHF, a Tribally run, non-profit health care facility located on beautiful Duck Valley Indian Reservation. We are an ambulatory clinic providing primary care services to the men, women and children of the Shoshone-Paiute Tribes and the surrounding areas. For more information or to apply on-line visit our website at shopaltnurses.org or call 208-403-8403 extension 200 and speak with the Director of Nursing.
INA is pleased to honor deceased registered nurses who graduated from Idaho nursing programs and/or served in Idaho during their nursing careers. Included, when known or when space allows, will be the date when deceased and the Idaho nursing program. The names will be submitted to the American Nurses Association for inclusion in a memorial held in conjunction with the ANA House of Delegates. Please enable the list’s inclusiveness by submitting information to rmidaho@idanurses.org.

Croft, Jean Rose Anna McHan, 10/03/2014. Jean was born in Idaho Falls and later graduated from Boise State University in 1966 with an Associate Degree in Nursing. She worked as a registered nurse at West Valley Home Health and St. Alphonsus Medical Center in Boise and as a facility standards examiner for the Idaho Department of Health and Welfare. Jean loved Idaho’s outdoors and was an active member of the Treasure Valley Orchid Society.

Countryman, Karen Teresa, 10/21/2014. Karen graduated from Boise State College and began her nursing career at St. Luke’s Hospital in Boise. She later enjoyed dual careers in nursing and social work and was employed as a child welfare worker, eligibility examiner, and quality control auditor for the Idaho Department of Health and Welfare. She loved helping others and solving problems and continued as a registered nurse at St. Alphonsus Regional Medical Center and the Elk’s Rehabilitation Hospital in Boise. She lived life fully up until the last.

Drape, Joyce Ann, 11/26/2014. Joyce received her BSN through Walla Walla College and an MSN at Loma Linda University. She was a longtime, dedicated nurse working at Gritman Medical Center in Moscow, Idaho. Her students knew her as a beloved and caring nurse educator who was committed to her patients and profession.

Hamilton, Darleen Ann, 11/20/2014. Darleen began her nursing career as a candy stripper and earned her nursing degree at Montana State University. She had a fulfilling nursing career working at St. Luke’s Medical Center in Boise and retired there after 27 years of service as a night shift charge nurse in the Emergency Department. She was a leader and mentor to those with whom she worked. After retirement from nursing, Darleen continued to serve others as an active volunteer for many community organizations.

Jones, Ruby Jane Hazen, 11/7/2014. Ruby was an extraordinary nurse who dedicated 23 years to caring for oncology patients at St. Joseph Regional Medical Center in Lewiston. She was honored for her dedication to patients and students with several Nurse-of-the-Year awards. Ruby served on three Work and Witness mission trips to Honduras, and completed the Susan G. Komen 60-mile breast cancer walk in honor of her two daughters, who are breast cancer survivors. Loving and caring for others became her passion and joy. Her role as a nurse allowed her to share her compassion every day.

Wermers, Audrey F. Smith, 10/12/2014. Audrey graduated with her nursing degree from St. Luke’s Hospital in Boise in 1954. She later became a Certified Registered Nurse Anesthetist and practiced in the Boise area for over 30 years. She was committed to her profession and missed by all she touched.

Good News!! Safer Patient Care and Cost Savings: Making Progress

A recent AHRQ annual interim report of hospital-acquired conditions (HACs) rates, cost savings, and patient deaths has been published. Data from nine specific data sites infections, ventilator-associated pneumonias, and post-op venous thromboembolisms.

Major Outcomes for 2010 to 2013

- 17% decline in HACs from 2010 to 2013.
- An approximate health care cost savings of 12 billion dollars.
- An estimated 59,000 fewer patients deaths in the hospital due to a reduction in HACs.

Specific causes of the decline in HACs are not clear yet, although findings are thought to be associated with:

- Dedication by hospital to implementing quality improvement and safety measures;
- Medicare payment incentives, and
- Partnership for Patients Initiative led by the Centers for Medicare & Medicaid Services (CMS)

Idaho Nursing Action Coalition: Recapping the Progress Made in 2014 by Sandie Nadelson, RN, PhD, Idaho Nursing Action Coalition Email: sandienadelson@gmail.com

This last year has been a busy one for the Idaho Action Coalition and the Future of Nursing: Campaign for Action. The Campaign has had some significant accomplishments in 2014 including: advancing nursing education, increasing access to health care, promoting diversity in nursing, recognizing ten extraordinary nurses through the “Breakthrough Leaders in Nursing” award, highlighting the economic benefits nursing brings to health care, and promoting nurses on governing boards.

A Call for 10,000 Nurses to Serve on Leadership Boards

The Campaign for Action is encouraging nurses to participate on leadership boards such as hospital boards, the United Way, and other organizations which impact the health of communities. Nurses need to be on governing boards for a variety of reasons. One benefit to having nurses on boards is that nurses in key decision making seats help health care consumers be better represented when tough choices are being made about issues that can promote healthy communities.

To make a significant ongoing change, many nurses need to be on boards. The Campaign for Action has set a goal of 10,000 nurses on governing boards by 2020. A variety of organizations are partnering with the Campaign for Action to help reach this goal. These include the American Nurses Association, the AARP, the American Assembly of Men in Nursing, the Robert Wood Johnson Foundation, Sigma Theta Tau, and the state-led Action Coalitions. The collaboration between these entities will certainly help promote having more nurses on boards. However, there are several challenges facing the Campaign for Action and state Coalitions in meeting the target. One is tracking how many nurses serve on boards. We have found that it is not an easy task to find out which nurses are currently board members and to keep a record of changes.

We are asking for your help with this. If you are involved or will be on a governing board, please let us know. Please contact Margaret Valori (mvalori@nurseleaders.org) or 208-367-1471. To find out more about the Campaign’s progress towards reaching the goal of 10,000 nurses on governing boards by 2020, go to: http://campaignforaction.org/news/join-effort-get-10000-nurses-boards-2020
An Evidence Summary: Does Medical Abortion Compared to Surgical Abortion Affect Outcomes for the Baby in a Subsequent Pregnancy?

by Angela Tramelli, R.N., BSN-DNP student, Gonzaga University, Spokane, Washington Email: atramelli@zagmail.gonzaga.edu

According to the Guttmacher Institute, “In 2008, six million abortions were performed in developed countries and 38 million in developing countries” (2014, p. 1). Numerous women are impacted by unplanned pregnancies. Abortion therefore becomes a decision that directly affects the lives of many. Abortion laws and alternative methods to surgical abortion vary worldwide and women in need of counseling for pregnancy options are commonly encountered throughout the healthcare arena. With evidence-based understanding of various abortion procedures and the implications that these approaches may have on health outcomes of babies, practitioners can provide thoughtful counseling and education which can support improved quality and safety in regards to this procedure. Ensuring that women with unwanted pregnancies know all of the options, outcomes, risks and benefits of the procedure will promote patient-centered care. The purpose of this evidence summary was to assess varying outcomes that medical and surgical abortion have on the health of babies in the mother’s first subsequent pregnancy.

Clinical Question
The following question guided the evidence search and summary: In reproductive age women with unplanned pregnancy (population), how does medical abortion (intervention) compared to surgical abortion (comparison) affect health outcomes of the baby (outcome) when evaluating birth weight and preterm delivery in the first subsequent pregnancy (time frame)?

The Search for Evidence
A comprehensive systematic search of the literature was conducted by accessing the National Guideline Clearinghouse, the Cochrane Database of Systematic Reviews, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PubMed. Inclusion (available upon request) and exclusion criteria for studies were determined a priori. Excluded studies were those that involved women undergoing spontaneous abortion and requiring further intervention and those studies looking at women undergoing abortion for medical reasons. The initial search terms were: “abortion, induced,” “medical abortion,” “surgical abortion,” “pregnancy outcomes,” “pregnancy complication,” “medical abortion,” “surgical abortion,” and “abortion, drug induced.”

Evidence Findings
Nine studies were selected as meeting inclusion criteria. Two of these studies were level I evidence on the evidence hierarchy, a systematic review (Lowit, Bhattacharya, & Bhattacharya, 2010) and a clinical practice guideline (NCG, 2014). The seven other studies included in this evidence summary were cohort studies. Lowit et al. (2010) concluded in a systematic review that “very few studies have looked at the relationship between medical IA (induced abortion) and LBW (low birth weight), but those that have, have failed to find any association” (p. 677). Individual cohort studies reported many different and somewhat conflicting conclusions.

Regarding preterm birth Lowit et al., (2010) found that, “although the evidence for association between PTB (pre-term birth) and IA is conflicting, recent systematic reviews as well as primary studies suggest that women who have undergone an IA are at a higher risk for PTB in subsequent pregnancies” (p. 678). The researchers also noted an increase in PTB with repeated induced abortions.

Individual cohort studies reported conflicting results regarding medical and surgical abortion in regards to pre-term birth. Two cohort studies, (Bhattacharya et al., 2012) and (Hardy, Benjamin, and Abenhaim, 2013), found surgical abortion increased the risk of subsequent pre-term birth while the five other cohort studies, (Gan, Zou, Wu, Li, & Liu, 2008), (Klemetti, Gissler, Niinimaki, & Hemminki, 2012), (Mannisto et al., 2012), (Virk, Zhang, & Olsen, 2007) and (Woolner, Bhattacharya, & Bhattacharya, 2013), noted no significant difference when comparing medical and surgical abortion in relation to the birth weight and pre-term birth of the baby in the first subsequent pregnancy. In the two cohort studies where surgical abortion was found to cause a higher incidence of pre-term birth, potential biases limit application of findings to practice. The sample size for women undergoing surgical abortion was much larger than the sample of women undergoing induced medical abortion and control of confounding variables was lacking when compared to cohort studies that found no differences between the intervention and comparison.

limitations of the evidence
Evidence presented in this summary was graded as insufficient with a low level of certainty according to the Grades of Evidence scale. More research is needed to determine the effects and possible differences in outcomes between medical and surgical abortion.

Overall, this author found insufficient research studies and a lack of full documentation explaining the medical and surgical abortion procedures utilized in these studies. In order to compare medical and surgical abortion outcomes, criteria such as gestational age of fetus at termination and the specific procedure for medical or surgical termination of pregnancy should be provided. Several cohort studies compared medical abortion versus surgical abortion specifically, but with medical abortion being more commonly performed in the first trimester now; updated studies need to be conducted to assess
A Doctorate of Nursing Practice (DNP) Scholarly Project: Continuing Professional Development (PD) and/or Active Nursing Practice for Idaho Registered Nurse (RN) License Renewal

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I have no conflict of interest, financial or otherwise, and I have no commercial affiliations.

Moving to Idaho in recent years, this author was introduced to registered nurse (RN) license renewal that does not require supporting documentation of continuing professional development (PD) and/or active nursing practice. This was intriguing. Why the difference between the states? Why were both PD and active nursing practice required for license renewal in other states but not in Idaho?

For my Doctor of Nursing Practice (DNP) scholarly project, this author decided to address nurse competency, patient outcomes, and RN license renewal requirements. The author collaborated with Idaho State Board of Nursing (SBON) and created a questionnaire regarding nurse license renewal in Idaho. These questionnaires were sent to Idaho licensed RNs. Questions were designed to identify participants’ demographics, their beliefs and attitudes regarding PD and/or active nursing practice as a requirement of license renewal, and the incentives and barriers to participation in PD and/or active nursing practice. This article includes excerpts from my scholarly project and its findings.

Background

For years, many SBONs and national professional nursing organizations have supported the need for continuing PD and/or active nursing practice as a minimum requirement for license renewal as a RN. They believe these activities will lead to RNs providing competent, safe nurse care which produces positive patient outcomes (Anonymous, 1972; National Council of State Boards of Nursing (NCSBN), 2005). Unfortunately, these state boards and organizations are unable to arrive at a consensus of what the most effective implementation and evaluation methods are for measuring PD effectiveness correlating with RN competency (Griscti & Jacono, 2006; Wendt & Alexander, 2007; Wilkinson, 2013).

Research and evidence is lacking in showing how PD and/or active nursing practice translates into RN competency or active nursing practice as a direct result of years of experience and formal education (Bigbee, Ottowes, & Gehrke, 2010; Tame, 2013). Research also has discovered a decrease in patient falls associated with an increase in a number of certifications among RN staff (Kendall-Gallagher & Blegen, 2007).

Characteristics of RNs Licensed in Idaho

In general, the personification of an individual with an active RN license from the state of Idaho is female; 50-59 years old; employed full-time in a hospital/acute care setting; licensed for 20+ years; certified in some area of nursing; and licensed in another state which mandates either PD or active nursing practice for license renewal in that state. RNs licensed in Idaho are typical of the national nursing workforce: experienced, middle-aged, and soon to retire. The major barriers to participating in PD cited by the respondents were lack of time and finances, while the top incentives for participating in PD were professional/personal achievement and ability.

Responses to Questionnaire

There were 227 responses to the 633 questionnaires distributed, for a response rate of 35.9%. Nearly every respondent indicated that PD and active nursing practice were important to becoming competent and maintaining competence in nursing practice. A large majority indicated they participate in PD voluntarily and incorporate change into their practice as a result of the participation. The majority of the respondents answered that they were in support of the Idaho SBON mandating RNs to participate in PD and/or active nursing practice. However, there was an even split in responses when asked if the Idaho SBON should incorporate both PD and active nursing practice requirements for license renewal.

Currently, Idaho’s SBON does not require PD activities or active nursing practice to renew a RN license. However, Idaho’s SBON has a desire to be proactive, thus they chose to revisit this stance (S. Evans, personal communication, 2011). There is also a lack of research and evidence indicating that RNs who do not engage in PD and/or active nursing practice are not competent (NCSBN, 2005). However, research does show that there is an increase in knowledge and confidence among RNs with PD and/or active practice.

This knowledge and confidence brings a change in their nursing practice as a direct result of years of experience and formal education (Bigbee, Ottowes, & Gehrke, 2010; Tame, 2013). Research also has discovered a decrease in patient falls associated with an increase in a number of certifications among RN staff (Kendall-Gallagher & Blegen, 2007).

Implications for Nursing

The findings from this scholarly project elicited additional thought-provoking questions:

- Why would an aging RN workforce of Idaho nurses support changing license renewal requirements at the end of their careers?
- Are registered RNs experiencing something within the current healthcare system which directed them to allow in response to mandating PD and/or active nursing practice?
- Since the large majority of nurses support a change in their practice and would participate voluntarily in PD and/or active nursing practice, do they understand the value in these requirements?
- Why do some RNs not participate in any nursing activities?
- Why did those extremely rare and few nurses indicate PD and/or active nursing practice are not important in becoming competent and remaining competent?
- Why have some SBONs incorporated these activities while others have not?

References


Griscti, O., & Jacono, J. (2006). Effectiveness of continuing education in perioperative nurses’ relationships with colleagues and sensitive rural lifestyle, this is a great job opportunity for you.

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NURSING

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כותנה ו detalles

IDAHIO SBON mandating RNs to participate in PD and/or active nursing practice, do they understand the value in these requirements?

Why do some RNs not participate in any nursing activities?

Why did those extremely rare and few nurses indicate PD and/or active nursing practice are not important in becoming competent and remaining competent?

Why have some SBONs incorporated these activities while others have not?

Doctors, pharmacists, nurse practitioners, accountants, and many other licensed professionals participate in PD activities no matter where they are located. As licensed professionals, nurses are put in a position of trust by the public. This would seem to demand an obligation for RNs to continue to develop professionally. One way to keep this trust is to continually engage in activities which can help us provide safe patient care while promoting positive patient outcomes.

In Idaho, the large majority indicated that PD and active nursing practice are not important in becoming competent and remaining competent. This is a great job opportunity for you.
An Evidence Summary: Are Platelet-Rich Plasma Injections More Effective than Hyaluronic Acid Injections in Reducing Knee Joint Pain?

by Michele Lingner MSN-FNP student, Gonzaga University, Spokane, WA Email: m.lingner@zmail.gonzaga.edu.

The author declares there are no conflicts of interest.

Millions of individuals around the world are afflicted with degenerative joint disease. In fact, according to Kon et al. (2011), it is “among the top 10 causes of disability worldwide” (p. 1491). The problem with degenerative osteoarthritis is that the damage is not reversible. One of the main components of joint osteoarthritis (OA) is degradation of the articular cartilage. Once this cartilage wears away, it starts to expose the joint surfaces and cause joint narrowing, inflammation and bone spurring, ultimately leading to severe arthritis and joint replacement (Ayhan, Kesmezacar, & Akgun, 2011, p. 352).

Hyaluronic acid (HA) and platelet-rich plasma (PRP) injections are therapies that are commonly used in the orthopedic community “as the last non-operative modality if other conservative treatments are ineffective” (Ayhan et al., 2014, p. 351). Both injections have unique characteristics. PRP injections use the patient’s own intrinsic healing factors found in the platelets of his/her blood (Say, Guler, Yener, Bulub, & Malkoc, 2013, p. 279). Once the blood is spun down and the platelets are separated, it is injected into the affected joint. HA injections use hyaluronic acid, a naturally occurring fluid that bathes joints. When articular cartilage is damaged, the formation of synovial fluid is disrupted, therefore accelerating joint damage. HA injections help to replace the synovial fluid to regain the “lubricating and shock-absorbing” qualities that the joint needs (Ayhan et al., 2014, p. 354).

The purpose of this paper is to report on evidence findings for the following clinical question:

**In patients with degenerative osteoarthritis of the knee, which platelet-rich plasma injections compare to hyaluronic acid injections in relieving joint pain at short term follow ups (one to three months) and long term follow ups (six to 12 months)?**

The Search for Evidence

A systematic search for evidence was conducted using the following electronic databases: The Cumulative Index of Nursing and Allied Health Literature (CINAHL), the Cochrane Library, PubMed, Medline and The Nursing Literature Clearinghouse. Based on the eligibility criteria, eight studies were selected and analyzed for this evidence summary.

Best Practices and Evidence Findings

The best practices that emerged from this research are that both PRP and HA intra-articular injections are highly effective in reducing pain related to OA. However, the overall advancements made evident that PRP injections seem to be the superior of the two in reducing pain levels and also sustaining its effect longer than HA. PRP injections are also theoretically deemed to be safer than HA injections. This is because its composition is autologous in nature, therefore eliminating the risk for immune reaction (Say et al., 2013, p. 282).

It is also recommended that other interventions be considered before turning to injections since they are minimally invasive procedures (Ayhan et al., 2011, p. 352). As evidence, the majority of the studies published only included patients who had been symptomatic for several months and had failed with pharmacological therapy, physical therapy, bracing or other interventions.

Every study that was used, to some degree, supported the use of PRP over HA injections in patients with knee OA. Several outcomes and statistical measures were used to determine the effectiveness of each injection, some examples they were interpreted through the Visual Analog Scale (VAS), International Knee Documentation Committee (IKDC), Knee Scoring System (KSS), Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC), Knee Injury and Osteoarthritis Outcome Score (KOOS) and the Tenger Lysholm Scale. Not only did the studies address the overall effect, they also addressed the short term and long term outcomes. Seven of the eight analyses studied, noted that there was a significant advantage of PRP over HA. Only one study, by Filardo et al. (2012) concluded that there was only a slight advantage of PRP over HA. In summary, the short term effects between one and three months saw great improvement with both the PRP and HA injections. However, PRP injections in most cases resulted in significantly better than the HA groups. Typically, both injections had strong outcomes at the third month, but by the sixth month, HA injection improvement started to diminish while the PRP scores continued to improve.

One study provided data from a one year mark. Chang et al (2014) and Filardo (2012) both determined that even at the 12 month follow up, results were still being seen in the PRP group, whereas there was no benefit seen in the HA group. Other elements that were considered in many of the findings were the variables of age and degree of OA present. There seemed to be a correlation between both age and OA progression with substantial outcomes for both injections. The consensus amongst the studies was that any damage of a grade III or higher on the Kellgren and Lawrence scale resulted in minimal benefit.

Evidence Conclusion & Application to Practice

The clinical guidelines established by the American Academy of Orthopaedic Surgeons (2013) addressed the use of PRP injections and HA injections in symptomatic patients. The guidelines stated they were unable to recommend PRP treatments due to the “lack of controlled prospective and randomized clinical trials with placebo effects” (p. 856). They indicated that emerging evidence may change their recommendation and that practitioners should utilize patient preference in deciding to use this treatment. Considering current current evidence, there is still some strong evidence favoring the efficacy of PRP.

The Academy found strong evidence to support a recommendation against use of HA for patients with symptomatic osteoarthritis (2013, p.770). This conclusion was based on an evaluation of the quality of evidence and the results showing that the efficacy of HA did not result in a “minimum clinically important improvement threshold” (p. 770).

Lastly, when considering intra-articular injections, prospective patient populations should be assessed carefully and meet standard criteria to ensure probability of a net benefit. This should be done by examining patient radiographs, pain scores, and previous failure of other minimally invasive interventions.

In conclusion, utilizing eight current studies, PRP appears to be superior to HA. It is also a low risk treatment and an inexpensive injection that has shown promising effectiveness in the reduction of OA knee pain over a span of six months.

References


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February, March, April 2015
The lack of consistent data collection methods and the lack of standardization of how TBI is assessed, treated, and managed is also a significant barrier. Although there is a wide range of services available to address medication use and onset of TBI with a comparison to the use of the medication Escitalopram caused by stroke or non-progressive brain damage. One of the most compelling and substantive study discovered during the literature search was a report by Tanielian et al. (2008), entitled the “Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.” This 499 page monograph provided an in-depth overview of the current state of medical care and services provided to military members diagnosed with MD, PTSD, and TBI. Despite the lack of high-level research to support any evidence-based practice recommendations with regards to significant outcomes in the treatment of TBI in addressing the PICOT questions, this monograph provided the best comprehensive resource on the scope of the TBI problem, current treatment options available to address medication therapy, and rehabilitation efforts for military members diagnosed with moderate to severe TBI. With a focus on prevalence, cost, and care systems, this report provided four recommendations:

1. Increase the cadre of providers who are trained and certified to deliver proven evidence-based care, so that capacity is adequate for current and future needs.
2. Change policies to encourage active duty personnel and veterans to seek needed care.
3. Deliver proven, evidence-based care to service members and veterans whenever and wherever service is provided.
4. Invest in research to close information gaps and plan effectively. (Tanielian et al., 2008 pp. xxviii-xxxii)

One of the more important conclusions provided by the authors was that addressing service members deployed to Iraq and Afghanistan with PTSD, MD, and TBI should be a national priority. The authors write, is that for TBI, “the science of treating traumatic brain injury is young” (Tanielian et al., 2008, p. 443). Two of the eight studies in the evidence search provided information on the use of psychostimulant medication therapy and application to patients with moderate to severe TBI in a study by Chew and Zafonte (2009), the use of Methylphenidate was supported as a medication helpful with cognitive impairments of concentration, processing speed, and vigilance in patients with moderate to severe TBI. A similar study by Arciniegas, Frey, Newman, and Wortzel (2010) discussed the use of Methylphenidate and provided recommendations regarding dosage and administration. Neither study, however, was able to provide time parameters from start to finish of medication use and the impact of medication on executive function. Thus, neither was able to assist with answering the PICOT question.

A third study by Chung, Pollock, Campbell, Durward, and Hagen (2015) completed a meta-analysis on adults 16 years of age and older having executive dysfunction caused by stroke or non-progressive brain damage. One of the three research questions in the study came close to the PICOT question for this paper as it compared cognitive rehabilitation to the use of the medication Methylphenidate in improved executive function in the study groups. The small sample size, however, precluded the ability to generalize the findings and the authors recommended continued research with a larger sample size.

The remaining five studies in the evidence search provided inconclusive data to support the PICOT question. Despite the availability of meta-analyses and Level One research studies that were available in the PICOT question, some of the limitations in the studies included bias (Brasure et al., 2012), lack of evidence for program effectiveness due to standardizations of both intervention strategies and controlled outcome research (Trudel, NiflièD, & Barr, 2007), and the fact that rehabilitation for brain injury is individualized and can be a long-term process, making it difficult to draw general conclusions (Turner-Stokes, Nair, Sedki, Disler, & Wade 2005).
Six Questions: How Student Nurses Utilize the Transcultural Assessment Model for Self Reflection

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I have no commercial affiliations and no conflicts of interest.

Reducing health disparities and achieving equitable health care are vital objectives for the United States healthcare system (American Association of Colleges of Nursing, 2008). One way to view this is as a “foundational pillar for reducing disparities through culturally sensitive and unbiased quality care” (Agency for Health Care Research and Quality, 2014, p. 1). Culturally competent care respects diversity and is more respectful of the patient’s culture and personal values (McClimens, 2008). Communication styles, attitudes, beliefs, and behaviors that attribute to health and wellness (Agency for Health Care Research and Quality, 2014). The purpose of this paper is to suggest the use of a framework to help student nurses understand cultural awareness and to stimulate through self-reflection their examination of values and actions promoting culturally competent care.

Standards for Culturally Competent Care in Nursing Education

The nursing profession has supported the importance of culturally driven health care. The Commission on Collegiate Nursing Education (NCN, 2006) suggests that diversity education in nursing programs is the first step in preparing a nursing workforce that can provide compassionate, culturally safe care to diverse individuals and populations. The National League for Nursing (NLN) states that nurses traditionally make preparing competent and culturally safe student nurses a priority in curriculum design and implementation (2012). Most nursing programs have heeded the call for culturally competent nurses and address this importance in college and program mission statements or course outcome statements. Additionally, accrediting bodies and approval boards such as the American Association of Colleges of Nursing (AACN, 2008) and the NLN (2012) have expectations that culturally sensitive care is included in curricula. Despite the call, there is conflicting and limited research to help us determine which are the best methods to teach cultural diversity to the next generation of nurses.

Student nurses’ perceptions of cultural diversity are frequently influenced by society’s definitions of these topics. These are often related to shared patterns of values and learned behaviors that have transferred over time. Student nurses’ ideas are based on multiculturalism and celebration of diversity, as well as an awareness of discrimination and increased acceptance; but these societal definitions and personal values can mislead nursing students to accept and increased acceptance; but these societal definitions and personal values can miss understandings, either through spoken words or body language!” and “Have I ever been treated differently related to mental health or learning disabilities?”

Time

To understand individualistic views of culture, student nurses must assess patient views about passage of time, points in time, and duration of time. Many countries and cultures are oriented with a focus on the past. These cultures value tradition and doing things as their predecessors have done. This can lead to resistance to new technology or treatments. Some cultures stress the present and may seem relatively unconcerned with the future. These individuals may disregard preventative measures and may not be late or miss appointments (Giger & Davidhizar, 2004). Student nurses may question their personal and cultural views related to time. “Is the present, past, or future most important to me?” and “How does my view of time reflect in my personal health choices?”

Space

Humans vary greatly in their comfort level related to personal space. Some of these spatial concerns are related to personal preferences, while others are a reflection of cultural principles. Student nurses must be aware of their patients’ comfort level related to body distance during conversation, proximity to family members, perception of space, eye contact, and personal and cultural touch practices (Giger & Davidhizar, 2004). Student nurses may question “What is my personal comfort level related to touch, eye contact, and conversational distance?” and “Can I identify a situation where I was made uncomfortable by another individual related to my personal space?”

Social Organization

Humans often learn and adopt cultural beliefs through social organization. Individuals from culturally diverse backgrounds will all manifest different degrees of acculturation into the beliefs of their dominant culture. In some circumstances, cultural values stem from the opinion of elders or patriarchs, while others place value on position in family. In this context, student nurses need to factor in geography, socio-economic status, religious affiliation, gender and sexual orientation, as well as age and life cycle status (Giger & Davidhizar, 2004). Student nurses could self-evaluate by pondering these questions: “What role do my parents and family member play in my beliefs?” and “Have my cultural views changed related to my current stage of life?”

Environmental Control

Environmental control can be explained in the patient’s ability, within their own environment, to plan activities that control their environment as well as their perception of personal control over factors in the environment (Giger & Davidhizar, 2004). Examples of assessment factors which play a role in environmental control are locus of control, folk medicine, and health beliefs. Student nurses need to understand that these issues play an extremely vital role in the way patients define illness and wellness, utilize health resources, and respond to health-related experiences (Eggenberger, Grasley, & Restrepo, 2006). Questions that student nurses might ponder are: “Am I superstitions and do I believe that I am in complete control of my health and wellness?” and “What non-medical/alternative methods do I believe in and utilize to obtain health?”

Biological Variation

When assessing a patient’s cultural underpinnings, biological variations need to be evaluated carefully to avoid stereotypes and discrimination. These factors include race, body structure, genetic variations, nutritional preferences and psychological characteristics (Davidhizar, & Giger, 2008). Nursing examples include diseases related to specific ethnic groups as well as rural versus urban health. Student nurses must remember the uniqueness of individuals and that a person’s association with an ethnic group does not mean that the individual patient will follow the socially accepted definition of his/her biological foundation (Vandenber & Kalischuk, 2014). Questions that a nursing student might reflect upon with patients are: “What is an accepted stereotype related to your ethnic group that is not true about you?” and “What health care practice do you not participate in that most of your ethnic group does?”

Conclusions

As a challenging health care environment results from new technologies, scientific advances, and cultural diversity, today’s student nurses are faced with uncertainty, unknown boundaries and unfamiliar practice questions. It is crucial that student nurses understand their personal values, culture, and biases, as well as those of their occupation through knowledge and reflection of cultural assessment tools. This reflection will foster cultural awareness and promote competent practices that will allow student nurses to give safe, patient centered care (Ledec & Kotzer, 2009). Nursing curriculum that integrates cultural care theories and conceptual frameworks across the curriculum will give graduate student nurses the tools needed to tackle the challenge of reducing health disparity in the United States (AACN, 2008). Facilitating cultural competency through reflective awareness, empathy, active listening techniques, and appropriate theoretical frameworks can assist health care providers in delivering culturally safe care (Institute for Health Care Improvement, 2016).

References


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This paper represents an unbiased view with no financial interests and no conflicts of interest.

There are many nursing programs which offer an Associate degree of Nursing (ADN) and a few that offer a Bachelor's of Science in Nursing (BSN) in Idaho. While it is the intention of students in nursing programs to become registered nurses (RNs), many hospitals are requiring their RNs to have a BSN degree. This creates potential barriers to employment among associate degree (AD) prepared RNs. The majority of schools that offer an ADN are usually the technical and community colleges which do not offer bachelor's degrees. If AD prepared nurses want to be employed at hospitals that require a BSN, they are required to first finish their associate's degree and then apply to another school to complete their BSN. Students enrolled in a BSN program at the universities can complete their program at one setting. This paper will provide insights and implications for higher education for entry level nurses.

The IOM Future of Nursing Report
In 2008, the Robert Wood Johnson Foundation partnered with the Institute of Medicine (IOM). This group would later develop the report (IOM, 2014). A recommendation that has become very important and the topic of much conversation is the goal that 80% of the nursing workforce will have a BSN by 2020 (IOM, 2014).

BSN Education Impacting Patient Safety and Outcomes
Healthcare delivery is continually evolving. Many hospitals require nurses to have higher education preparation in order to serve in nursing leadership roles including charge nurse, nurse educator, manager, and/or director (Morgan, 2014). The largest hospitals in Idaho are moving in this direction by requiring their nursing staff who are not already prepared at the baccalaureate level to be enrolled in a BSN program within three years of hire. This is becoming a nationwide norm (IOM, 2014). The BSN curriculum includes education in leadership and management, population health, evidence-based practice, and wellness. Education in health promotion, risk reduction, illness and disease management, and overall health maintenance is provided by the healthcare delivery system (Ellis, 2007) to optimize health outcomes among individuals, families, communities, and populations. Baccalaureate prepared nurses are better prepared to work in public health, school health, and other community settings as well as leadership roles (Ellis, 2007).

More education for nurses translates to better patient safety and outcomes. “Repeat studies over the years have shown that there are fewer patient safety problems if the patient care is carried for by nurses with higher degrees, like BSNs,” said Cheryl Wagner, PhD, associate dean of graduate nursing programs at American Sentinel University in Aurora, Colorado (Brimmer, 2013, para 2). Linda Aiken, an esteemed nursing leader of our day, also demonstrated this in an extensive research that BSN prepared nurses were associated with lower mortality rates and overall better outcomes for patients. “Each 10% increase in the proportion of nurses with higher degrees decreased the risk of mortality in patients to be rescued by a factor of 0.95, or by 5%, after controlling for patient and hospital characteristics” (Aiken, Clarke, Cheung, Sloane, & Silber, 2003, p. 1620).

Brimmer (2013) concluded that it is difficult for a nursing student to learn everything required for nursing in two years. The hospitals are realizing this also and have been pushing for AD prepared nurses and potential new hires to obtain their BSN to even be considered as an entry level nurse. Those veteran nurses who have had an associate’s degree for decades have been even asked to return to school within the next 10 years and receive their BSN.

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Nursing

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varying outcomes between medical and surgical abortions. Gaps in knowledge are evident in the conflicting findings across the cohort studies. Standardization of required baseline and outcome data and well documented protocols would benefit many providers. Data could then be compared and analyzed to promote positive health outcomes for both the mother and baby.

Practice Recommendations

When comparing surgical abortion to medical abortion in the first trimester to determine the effect on pre-term birth and low birth weight babies, the author found moderate certainty that surgical abortion may contribute to pre-term birth. However, there is not enough evidence regarding the likelihood of medical abortion producing the same outcome. Insufficient evidence exists to determine whether medical versus surgical induced abortion contributes to low birth weight babies in the subsequent pregnancy. Therefore, a provider should not recommend or promote one type of induced abortion over another type. Evidence is lacking about the balance of benefits and harms associated with the two interventions.

Best practices based on this body of evidence would include a provider offering patient education addressing the mother’s perceived outcomes of induced abortion on subsequent pregnancies. Patient education should include information about the possibility of preterm birth after undergoing surgical induced abortion. When discussing the possibility of low birth weight as an outcome, the provider should disclose that not enough evidence supports medical abortion over surgical abortion. The National Clearinghouse Guideline (2014) for induced abortion are in agreement with this authors’ findings as both surgical and medical abortion are listed as appropriate modalities for first trimester termination of pregnancy. No specifications regarding risks or benefits of one induced abortion over another are noted in the NCG.

Patients should be thoroughly educated about each method; providers should address their concerns about each procedure and outcome for their baby in the subsequent pregnancy. Due to similar risks between surgical and medical abortion, counseling of women requesting termination of pregnancy can be tailored to their unique needs. Current evidence based knowledge should be presented in a way that informs the patient of all possible risks and benefits of each procedure in relation to specified outcomes.

References


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