President's Pen

Nursing Advocacy for Patients and the Profession

Teresa H. Huber, DNP, MSN, RN

Nurses are accustomed to serving as patient advocates, by putting the patient’s needs, desires, and safety first, working to protect patient’s rights, shaping health policies, and participating in many other activities. Nurses may also advocate for each other and the professional association in which they belong. Advocacy is defined by the Merriam-Webster Collegiate Dictionary as the “act or process of advocating or supporting a cause or proposal” while an advocate is defined as “a person who argues for or supports a cause or policy.” While many nurses readily accept the nurses’ advocacy role with patients, advocacy on behalf of our co-workers and colleagues may not be so clear.

Challenging issues and events in healthcare over the last several years have impacted every practice setting. These issues continue to evolve, such as healthcare reform, financial pressures, technology, changes made by regulatory agencies to improve quality and patient safety, and workforce staffing issues. These events can have a negative impact on the work environment, causing stress, fatigue and depression. It is well documented in the literature that stress contributes to illness and many disease processes. However, these healthcare system dynamics can also create advocacy opportunities for nurses and the nursing profession.

Advocacy for the nursing profession developed many years ago as nursing leaders formulated the Code of Ethics for Nurses with Interpretive Statements. The Code (2015) clearly outlines safe practice environments which include our advocacy role for one another. From the Code: “nurses maintain professional, respectful, and caring relationships with colleagues, and are committed to fair treatment, transparency, integrity-preserving compromise, and the best resolution to conflicts” and “the nurse creates an ethical environment and a culture of civility and kindness treating colleagues, co-workers, employees, students and others with dignity and respect.”

Advocacy presents itself as an opportunity when nurses are involved in teaching nursing students and new bedside nurses. Students and new nurses view practicing nurses as role models and mentors, and are excited to be entering the profession. Role modeling professional behavior and teaching those new to the profession to acquire these behaviors is an advocacy opportunity. In Benner’s (2010) article, there are many ways in which faculty and nurse educators in professional development roles, as well as the nurse preceptor/mentor, serve as the “culture carriers” for the profession. “These educators are pivotal in the formation of nurses’ professional identity as advocates, an identity that transcends carriers” for the profession. “These educators are pivotal in the formation of nurses’ professional identity as advocates, an identity that transcends their entire career.”

Nurses can be involved in advocating for the nursing profession and each other by serving as role models and speaking with others about the work they do. Nurses comprise the largest professional group within healthcare and have been recognized by the public as the most trusted profession, several years in a row.

Curtin (2015) writes “to the extent that nurses recognize their interdependence, their commitment to common goals, the similarity of their fundamental knowledge base, and their indebtedness to the nurses who went before them, they will be willing to devote themselves to advancing their profession and promoting the growth of younger colleagues. As a caring profession, nursing involves not only care for and of patients, but also care of and for nurses.”

Advocacy skills, not only for our patient, but for ourselves, are becoming increasingly important in this ever-changing healthcare environment. Nurses should engage in their professional associations, and contribute to the accountability and voice of the profession. It is a wonderful time to be a nurse, and by demonstrating and sharing our advocacy skills, and advocacy for our profession, we will enhance our nursing care and the care of our patients.

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KNA Centennial Video

The Human Touch

Accent on Research

Cultural Diversity

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President’s Pen

Issues & Insights
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• **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:
  - Research/scholarship/clinical/professional (Classical Peer Review)
  - Personal opinion/experience, anecdotal (Editorial Review)
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• Articles should be submitted electronically.
• Articles should include a cover page with the author’s name(s), title, affiliation(s), and complete address.
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*The Kentucky Nurse is published quarterly every January, April, July and December by Arthur L. Davis Publishing Agency, Inc. for the Kentucky Nurses Association, P.O. Box 2816, Louisville, KY 40201, a constituent member of the American Nurses Association. Subscriptions available at $18.00 per year. The Kentucky Nurses Association’s officers, or anyone acting on its behalf, do not make any warranty or representation, express or implied, concerning the accuracy or completeness of any information contained herein or the suitability of any product, service or software for any use. The Kentucky Nurses Association, Inc. shall not be held liable for any consequences resulting from purchase or use of an advertiser's product. Articles appearing in this publication express the opinions of the authors; they do not necessarily reflect views of the staff, board, or membership of KNA or those of the national or local associations.

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October, November, December 2015

"The purpose of the Kentucky Nurse shall be to convey information relevant to KNA members and the profession of nursing and practice of nursing in Kentucky."

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Chapter News

Bluegrass Chapter Update
Amy Herrington, DNP, RN, CEN
KNA-Bluegrass Chapter President

We had a very busy May membership meeting. We celebrated Nurses Day by providing a sponsored meal for all members in attendance.

As a commitment to our members, each membership meeting we provide a CE program. For our meeting in May, Dr. Jill Cornelison provided an excellent CE offering on establishing an evidence based practice program and system in a rural health facility.

Following the loss of our long time member, Karen Tufts, the board of the Bluegrass Chapter created an award in memory of our good friend. Our 2015 recipient Suzanna Stewart was recognized at our May meeting. Suzanna is a May 2015 graduate of Bluegrass Community and Technical College-Nursing program.

Recognizing our community service responsibilities, each meeting our members engage in a service project. For May, we collected for the Simon House. Simon House is a nonprofit transitional living facility located in Frankfort for homeless adult women who are pregnant or have children. The members collected $210 that will be used to purchase backpacks, juice boxes, crayons, stuffed animals, coloring books, tooth brushes and soap for children that arrive at the facility. These will be delivered by Laura Riddle to the organization.

We welcome you to our next meeting which will occur November 17th at the Chop House on Richmond Road in Lexington, Kentucky. We begin gathering at 5:30pm and our programming runs from 6pm to 7:30pm.

We can’t wait to see you there.

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Nightingale Chapter News

Nightingale Chapter, formerly District 9, will be awarding a $500 scholarship for the fall semester. To be eligible an applicant, must be enrolled in an ADN, BSN, Masters or Doctoral program and must reside or be employed as an RN within the chapter boundaries. These counties include Anderson, Boyle, Casey, Garrard, Lincoln, Marion, Mercer, Rockcastle and Washington. The candidate must submit a short essay on the benefits of belonging to a professional organization and a letter of support from at least one faculty member or employer. The deadline for submission is October 1, 2015. Please contact Denise Alvey at alveylex2@aol.com for further details and an application.

For information, about the day and time of our next meeting, please contact Jo Ann Wever chairperson at jowever@att.net.

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Unequal Access: African Immigrants and American Health Care

Access to health care is defined as the empowerment of an individual to use health care. It is a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households, and communities (McIntyre, Thede & Birch, 2009). Inequities in health care cover not only inadequacies in access to care but also differences in the quality of both informal and formal care, as well as the burden of payment. The existence and magnitude of these inequities increase the disease burden, widen social inequities in health status, and generate adverse social and financial effects (Dahlgren & Whitehead, 2007). When opportunities for efficacious health services are unavailable to certain groups in society, there are access issues that may need to be addressed (Guilliford et al., 2002).

Examining access to health care among African immigrants is an important and timely issue as a result of the growing health inequities related to health care access in this underserved population (Edward, 2014). The African immigrant group is a rapidly rising new population in the United States (Capps, Mc Cabe & Fix, 2012). From 1980 to 2013, the sub-Saharan African immigrant population in the United States increased from 130,000 to 1.5 million (Zong & Batalova, 2014). African immigrants differ by country of origin, reasons for migration, primary languages spoken, health practices and beliefs, human capital, education status, and cultural background (Reed & Tishkoff, 2006). Managing the health care needs of this group is challenging due to the diversity and vulnerability of the group.

Penchansky and Thomas (1981) conceptualized that access has five dimensions; (a) availability, (b) accessibility, (c) affordability, (d) accommodation, and (e) acceptability. These dimensions of access are interwoven and may not be easily separated. The purpose of this paper is to briefly explore the dimensions of access as it relates to African immigrants health using the model provided by Penchansky and Thomas as a conceptual guide.

Availability: Immigrants experience limited access to care due to citizenship status (De Alba, Hubbell, McMullen, Swenson, & Saitz, 2005; Echeverria & Carrasquillo, 2006; Goel et al., 2003; Ojikutu, Nnaji, Sithole-Berk, Bogart, & Gona, 2014; Othieno, 2007). The immigrant provisions of the 1996 welfare reform act, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), made most legal immigrants ineligible for publicly funded services such as Medicaid for the first five years of residence (undocumented immigrants are ineligible irrespective of their length of stay) but states can determine eligibility by funding services and/ or restrict the eligibility of qualified aliens (Derose, Escarce, & Lurie, 2007). Many immigrant families hesitate to enroll in critical health care, job-training, nutrition, and cash assistance programs due to fear and confusion caused by the laws’ chilling effects (Broder & Blazer, 2014). Uncertainty about government program eligibility and fear limit healthcare use. For example, when immigrants are out of legal immigration status, they may hesitate to seek care because of the profound fear of deportation (Othieno, 2007). Although millions of uninsured American residents gained access to healthcare coverage through the implementation of the Patient Protection and Affordable Care Act of 2010, millions more will remain uninsured due to mandates that forbid undocumented immigrants and legal residents of less than five years from purchasing insurance through the newly available market exchange (Agudin & Coffin, 2015).

Accessibility: Having knowledge of services and the proximity to health facilities may improve access to care. However, some African immigrants have reported that they do not know where to go for health care and are confused about how the U.S. health care system works (Boise et al., 2013). Accessibility of health care facilities can be influenced by geographical location. New immigrant settlements are less likely than established destinations to have well-developed safety nets, culturally competent providers, and immigrant advocacy or community-based organizations (Derose et al., 2007). Cities with strong community-clinic networks and a long history of serving immigrants still have uneven access to care (Okie, 2007). Immigrants living in rural areas may have limited access to specialty care, difficulty getting specialty care referral due to insurance status and they may have long wait times before getting appointment.

Affordability: The high cost of health care and lower socioeconomic status (SES) impacts the affordability of healthcare for the African immigrant

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.
population (Foley, 2005; Odedina et al., 2011; Wafufa & Snipes, 2013). As of 2013, 26% of Sub-Saharan African immigrants were more likely to be uninsured compared to the 12% native-born population (Batalova, 2014). Even though the majority of African immigrants are educated and have high labor force participation, their earnings are surprisingly low (Capps, McCabe & Fix, 2012). The underemployment is often due to recent arrival, difficulty transferring home country credentials and labor market discrimination (Capps, McCabe & Fix, 2012). Lower socio economic status is associated with poorer health status (Dunlop, Coyle, & McHaac, 2005). In two studies of African born patients attending HIV clinics in Minnesota, The researchers reported that African immigrants receive care at later stages of HIV infection or when they have AIDS and do not routinely get tested for HIV compared to US born population (Akinsele et al., 2007; Page, Goldbaum, Kent, & Buskin, 2009).

**Accommodation:** African immigrants have reported language difficulties as a barrier to healthcare access (Adekeye, Kimbrough, Ohafezi, & Strack, 2014; Boise et al., 2013; Carroll et al., 2007; Pavlish, Noor, & Brandt, 2010; Simbiri, Hausman, Wadenya, & Lidicker, 2010). Limited English proficiency affect the quality of care immigrants receive; for instance, immigrants with limited proficiency report lower satisfaction with care and lower understanding of their medical situation (Derose et al., 2007). Language barriers play a major role in health system navigation difficulty (Adekeye et al., 2014).

Although the use of interpreters may alleviate communication problem, it has some limitations. Boise et al, 2013 found that communicating through interpreters added to the complication of scheduling appointments; an aspect of health care that was an unfamiliar for many immigrants and some Africans are deterred from seeking care because of fear that private health information might be spread to the community by interpreters who lived in their neighborhood. Skills like reading, writing, communicating, and listening in English are needed to accomplish health related tasks. One needs familiarity with the technical, jargon-rich, biomedical vocabulary used within the health care system (Singleton & Krause, 2010), this may prove a challenge for immigrants for whom English language is not the primary language.

**Acceptability:** Discrimination experienced in health care settings may inadvertently influence individuals' use of needed health care (Quach et al., 1999). The underemployment is often due to recent arrival, difficulty transferring home country credentials and labor market discrimination (Capps, McCabe & Fix, 2012). In a study among a multiethnic population in the United States, African immigrants reported that they perceived that they were treated unfairly and some Africans are disrespected because providers portray racist attitudes and do not treat them as “a whole person” but as poor minority newcomers at the bottom of the socio-cultural ladder (Boise et al., 2013; Carroll et al., 2007).

**Implications for practice and research**

The Penchansky and Thomas framework (1981) is a useful guide in explaining the dimensions of access. The framework highlights healthcare access as a multidimensional concept requiring a comprehensive approach that encompasses far more than our traditional definition of access.

Nurses are at the forefront of patient care and have a significant role that includes providing appropriate and empathetic healthcare. In the case of immigrant populations this includes understanding and providing healthcare navigation and resources as highlighted by the application of the framework to access issues in African immigrants. For example, it is critical that nurses and other health care providers utilize professional interpreter services to facilitate effective communication and ensure patients' privacy. As nurses encounter immigrants and other vulnerable populations, they can address access equity not just through their individual patient care but as patients' advocates ensuring that all patients are treated with respect and dignity.

Policies addressing health access equity may improve health care use and better the overall health of all Americans. Improving cultural competence has been recommended as a strategy to address inequities based on the premise that improving provider-patient communication is an important component of addressing differences in quality of care that are based on the race, ethnicity, or culture of the patient (Betancourt, Corbett, & Bondaryk, 2014; Julliard et al., 2008; Morales, Cunningham, Brown, Liu, & Hays, 1999).
Unusual Access continued from page 5

Furthermore, educating recent immigrants about US healthcare services through more established community members and healthcare navigators may assist in achieving improved access and utilization rates of services. Education should be focused on areas such as scheduling, appointments and follow up, information about available programs and resources in the community, and strategies for effective communications with providers and how to be active participants in their healthcare decisions.

Finally, there is limited research addressing issues related to health care among African immigrants. Researchers should continue to provide data and knowledge of the health care needs of this growing population. The body of literature that results from this continued exploration will serve as a basis for improved practice and policies that better the health of African immigrants.

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Substance Abuse Among Nurses

Morgan Ivey
University of Kentucky College of Nursing

For over a century, it has been recognized that there is a moderately high prevalence of addiction among nurses; currently it is estimated that 20% of nurses have a substance misuse, abuse, and/or addiction problem (Monroe & Kenega, 2010). In 1980 the National Nurses Society on Addictions recognized that substance abuse was a prevalent issue among nurses, thus establishing a task force to confront the growing issue (Monroe, 2009). The task force was named the Peer Assistance Program, and was formulated by several nurses whom specialized in caring for patients suffering from addiction (Smith, 2013). The hope was that with the instillation of automated computerized delivery systems of medication, the prevalence of diverting among nurses would decrease, but there is no current evidence of this (Rundio, 2013).

Substance use disorder affects nurses more than the general population, as the general public is affected at a reported level of 16%, and nurses an estimated 20% (Monroe, 2009). This topic is one of concern, because it is thought that medical professionals may have an increased risk due to the high stress level of the healthcare field, the easy access to controlled substances, and variable working hours (Leff, 2014). As a nurse it is your duty to take care of others, and if you are not mentally, physically, and emotionally sound, you are not able to provide proper care. Moreover, nurses are continuously around medication, and they need to be comfortable handling and administering drugs.

Early detection of a substance abuse problem is important to provide early intervention, in order to ensure providing the upmost supportive and confidential treatment option, free of punitive action (Monroe & Kenega, 2010). Kunyk (2013) found that substance use was unknown by the employers of nurses whom were coded high for being at risk for impairment during practice, and were therefore continuing to work without treatment. Eighty-two percent of nurses have not notified their employers of having a substance use disorder because of the foreseen embarrassment of discussing it with others and 53% are worried that they could not obtain any meaningful help for their issue by discussing it (Kunyk, 2013).

Typically substance abuse among nurses begins early in a nurse’s career and usually begins while the nurse is still in school (Monroe, 2009). Massuse of prescription drugs seems to be the initial step of substance abuse among student nurses, whom later suffer from abuse of controlled substances in their workplace (Monroe, 2009). The epidemiology of substance abuse within nurses is broad; it affects all genders, socioeconomic and educational backgrounds, cultures as well as all geographic locations (Rundio, 2013). However, substance abuse tends to be prevalent among nurses whom are significantly younger, less experienced, and are female (Rojas, Joan-Slaughter, Brand, & Koos, 2014). Nurses with a substance abuse disorder typically feel as if they have a decreased level of organizational support from their employers, college, and local nursing associations (Kunyk, 2013). Recent studies show that of the nurses whom have a substance use disorder, 60% also have a co-occurring psychiatric illness, which is significantly higher than in the general population of 45% (Rojas et al., 2014). Moreover, those whom have substance abuse paired with a psychiatric illness, have higher relapse rates and require a more complex course of treatment (Rojas et al., 2014).

When polling nurses on which substances were the root of their addiction, the substances were ranked from greatest to least in the following order: opioids, alcohol, and benzodiazepines (Rojas et al., 2014). The Diagnostic and Statistics Manual 5 states that opioid use disorder is diagnosed as having a problematic pattern of use due to at least any two of the following criteria within a 12-month period (American Psychiatric Association, 2013): Taking a larger amount of opioids or for a longer than intended period, unsuccessful efforts to control use, spending a great deal of time in obtaining, using, or recovering from the opioid, craving, failure to fulfill major role obligations, continued opioid use despite having recurrent problems caused or exacerbated by the effects of opioids, important activities are given up or reduced because of opioid use, recurrent opioid use in situations in which it is physically hazardous, continued opioid use despite knowledge of having a problem that is likely to have been caused by the substance; signs of tolerance or withdrawal (para. 1).

Current Treatments and Interventions
The treatments and associated interventions used for Opioid Use Disorder are mentioned below. Some popular forms of treatment include opioid antagonist therapy, pain management, and psychotherapy (Prela et al., 2014). Individuals experiencing extreme cravings and withdrawal symptoms are placed on a regime of opioid maintenance therapy via the administration of opioid agonists (Prela et al., 2014). Buprenorphine, Subutex is a sublingual opioid agonist that is often used to decrease symptoms of withdrawal. Probuphine, a buprenorphine implant, can be used for opioid withdrawal, and delivers buprenorphine for 6 months, which has proven to be effective. Subutex can be combined with naloxone to form Suboxone, a sublingual treatment (Simojoki, Vorma, & Alho, 2008). If Suboxone is crushed and injected, the naloxone will cause a heavy withdrawal effect (Prela et al., 2014). Methadone may be used instead of Suboxone or Subutex, and it works as a full opioid agonist to reduce negative effects of withdrawal. Vivotrol

Current Treatments and Interventions
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(Smith, 2013). Their ability to appropriately function as a nurse is achieved by the responsibility of impaired nurses to co-workers and the individual healthcare facility to recognize that a nurse is working under the influence of a substance. Once the impairment has been identified, it is the responsibility of fellow nurses to approach the nurse supervisor (Monroe & Kenega, 2010). The hospital will then begin an investigation into the situation, starting with a confidential intervention, allowing the nurse to admit he or she has a problem, in a safe atmosphere (Monroe & Kenega, 2010). The nurse will then enter into a treatment program and typically will have a support group organized through the healthcare facility. There are several programs that offer an alternative to discipline, or ATD, approach, all of which mandate “a contract, expectation to complete appropriate treatment, participation in a support group, random drug screenings, workplace monitoring, and abstinence from controlled substances” (Smith, 2013, p. 466). After the nurse completes a treatment program, he or she will be able to begin medical practice again, under the close supervision of the state’s board of nursing to ensure patient safety (Leff, 2014). If a nurse refuses to enter into an ATD program, or does not comply to the above mentioned standards, the state board of nursing will be required under administrative procedural law to take official civil action against the nurse, in the form of nursing licensure probation, suspension or revocation (Monroe, 2009).

There are several different interventions and treatment options currently used specifically for nurses suffering from substance use disorder. The ATD approach is focused on assisting nurses and other healthcare professionals with treatment, rather than using punitive action (Monroe & Kenega, 2010). This approach focuses on the nurse to self-regulate and to increase safety and well-being, in order to prevent substandard nursing practice (Monroe & Kenega, 2010). The ATD goal is to allow impaired nurses to enter treatment in a confidential manner, without public disclosure (Monroe & Kenega, 2010).

An additional alternative to disciplinary action, is entering into a Peer Assistance Program, also known as PAP, which has the same goal as the ATD. The PAP is formed by addiction nurses in every hospital, which is suffering from a substance use disorder, many hospitals have ATD or PAP programs in place, to guide in the recovery process. Alternative programs, also help to ensure that an individual’s nursing licensure does not get revoked, with the strict adherence to the programs contract (Rundlo, 2013). These programs can be a great resource for nurses to use as they are a means of getting the help the individual needs without the repercussions of losing employment.

The Kentucky Board of Nursing put into effect the Kentucky Alternative Recovery Effect, or KARE, program (Kentucky Board of Nursing, 2012). The KARE program allows nurses to enter into treatment and receive a full recovery, as well as keep their nursing license, with compliance of the KARE program agreement. The KARE program is a therapeutic monitoring program leading to recovery, via education, and treatment of all substance use disorders.

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Substance Abuse continued from page 9

Nationally, the American with Disabilities Act, passed in 1990, protects the nurses whom are currently in substance use treatment, from having their licensure revoked by the state board of nursing (Rundio, 2013). This act has brought about more PAP and ATD approaches by the state board of nursing, rather than punitive approaches, which were much more before the act was passed (Rundio, 2013).

Practice, Education, and Research

Nursing students are educated about substance use disorder, and more specifically, opioid use disorder, during the programs' psychology course and associated lectures. I think it would be very beneficial to have a few lectures directed solely on the specifics of how healthcare providers are at an abnormally high risk of suffering from substance abuse. Offering education focused on the proper guidance for identifying reporting, and investigating substance abuse in healthcare providers, would be a beneficial addition to the bachelors of nursing curriculum. Most hospitals have identified a hospital specific policy as being directed toward drug use in the health care system. All hospitals have a policy against drug use by its employees, and it is within the employees' best interest to follow this policy. If they suspect that a coworker is having issues with substance use, he or she should report it to a manager.

Practitioners of a coworker suspected to have a substance use disorder, should report this to their manager. If he or she is having issues with substance use, he or she should report it to a manager. Evidence-based practice and research should be used while treating any patient for a substance use disorder, and it should be used while treating any patient for a substance use disorder. Nurses who are young, female, have been used while treating any patient for a substance use disorder, and should report it to a manager. If they are having issues with substance abuse in the workplace, and should be used while treating any patient for a substance use disorder. Nurses who are young, female, have been used while treating any patient for a substance use disorder, and should report it to a manager. If they are having issues with substance abuse in the workplace, and should be used while treating any patient for a substance use disorder, and should report it to a manager.

References


Kathy Bergman, M.S.N., R.N.C., C.N.S.  
Northern Kentucky University  
Highland Heights, Kentucky

The Northern Kentucky University (NKU) College of Health Profession boasts an established tradition of community involvement. Located in Highland Heights, Kentucky, a greater Cincinnati suburb, NKU’s community service has historically centered on the needs of the Kentucky counties surrounding the school. For example, programs have served the employees at the Turfway race course, the City Heights neighborhood in Covington and local residents gathered at the Madison Avenue Christian Church food kitchen. Recently this service has extended across the Ohio River to include the Cincinnati Public Schools (CPS).

This new relationship has been especially fruitful because of its uniquely symbiotic nature. The schools offer excellent teaching opportunities for the nursing students who in turn, while learning, provide services that are needed by the public school students. Each institution is better served by the connection.

NKU Objectives

The NKU College of Health Professions implements its commitment to the community in part through a robust Community Nursing course. This clinical practicum places students at sites where they study the needs of the local population, draw up a plan for a meaningful intervention and implement the plan through mentored interaction.

A goal of the course is to open students up to the needs of those in the area who have suffered socioeconomic disadvantages and to train them in nursing skills to help meet those needs. The course itself is an eight week course. The students are junior nursing students. Typically each clinical group consists of 8-10 students under the direction of an experienced nursing faculty member. The students are initially briefed on the site/population of an experienced nursing faculty member. The group consists of 8-10 students under the direction of an experienced nursing faculty member. The students are initially briefed on the site/population of an experienced nursing faculty member. The students are initially briefed on the site/population of an experienced nursing faculty member.

A Two Way Street: How a Nursing School and Public School System Help Each Other

October, November, December 2015 Kentucky Nurse • Page 11

This has been a successful template and is a popular course. A quantum leap forward has occurred with the recognition of the major needs of local primary and secondary schools. Enter the marriage of the NKU Community course to CPS.

Needs—CPS

CPS is a large diverse school system which educates 33,000 students in 43 elementary schools and 17 secondary schools. The Cincinnati Public School District covers an area of 91 square miles including all of the City of Cincinnati, Amberley Village, Cheviot and Golf Manor; most of the City of Silverton; parts of Fairfax and Wyoming; and small parts of Anderson, Columbia, Delhi, Green, Springfield and Sycamore townships. CPS has faced budget cuts and will need to deal with the historic struggle to meet the requirements of an underfunded urban school district. More than 71% students come from families below the poverty line. The needs of diverse populations are enormous.

Indeed many CPS students come from households where they are deprived of ideal healthcare at home. The lack of nutrition, dental care, basic medical care and education are constant problems facing the system’s administrators. Moreover, the schools do not have the level of funding required to have full time school nurses at every location. Thus, despite the need to have screenings performed, immunizations given and chronic illnesses addressed, there are simply not enough resources. It is a classic situation where the best intentions are insufficient.

A Good Fit

CPS and NKU nursing students were originally brought together through the collaboration of the Cincinnati Health Department and the author of this article, NKU faculty, Kathy Bergman. In 2012 when the author served as the Leadership Course Coordinator for the NKU Leadership Practicum she fortuitously met Kathy Reder, RN, BSN who was then serving as a Team Leader for School and Adolescent Health. Ms. Reder offered availability of experienced preceptors who could help the student nurses learn...
A Two Way Street continued from page 11

important leadership skills. This led to very positive change projects including “Feed the Bellies” at a Silverton school.

The success of the Leadership course in turn resulted in an association with Denise Murray, RN, BSN, also with Cincinnati Health Department, who is a Team Leader for School and Adolescent Health. Ms. Murray is another one of those dedicated nurses at the forefront of those seeking to meet the challenges facing CPS. She put the author in touch with various schools. In addition, the author, who was teaching in the Community practicum, was introduced to Cynthia Ransohoff, RN, also a School Health Team Leaders in charge of the School Health Assistants in the schools. Because of the efforts of these Cincinnati Health Department leaders the program has blossomed. Over the last two years, almost a dozen elementary schools have been served. The Community groups have assisted at many Cincinnati Public Schools including: North Avondale, Silverton, Academy of World Languages, Fairfield-Clinton, Hartwell, Pleasant Hill, Carson, and Rees E Price. The students have presented their Community Assessments on these different populations and NKU students cannot replace trained registered nurses at each school. Until our society has

opportunities. If a large number of these programs are able to efficiently work

which they may have not prior experience.”

and gives them exposure to a different side of nursing and to a population with

deadlines imposed. The nursing students’ assistance helps complete the task

for the school nurse to get all of the state mandated screening done by the

it was early on Monday mornings was another strength for me because it forced

me to work hard and want to learn and enjoy my time.”

some clinical rotations can be a bit boring but this one was actually extremely enjoyable. The fact that I actually wanted to be there even if it was early on Monday mornings was another strength for me because it forced me to work hard and want to learn and enjoy my time.”

Denise Murray has appreciated the assistance. She states, “collaborating with the nursing programs has been beneficial for both sides. It is very difficult

with the children at CPS and hope that they continue this clinical experience in

the future.” Another added “I really enjoyed working the schools.” And another called it, “a wonderful clinical experience’. A recent practicum student summed it up as follows “Some clinical rotations can be a bit boring but this one was

Collaboration with public school systems the manpower deficit and school nurse crunch may

cannot replace trained registered nurses at each school. Until our society has

which they may have not prior experience.”

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There was no significant difference in chronic fatigue or acute fatigue in the nurses who worked shorter shifts. The only statistically significant finding in this study was that nurses who worked the 12-hour shifts had quicker recovery times than the nurses who worked the 8-hour shifts. The significance value was p = 0.027. Therefore, the 12-hour shifts had quicker recovery times than the nurses who worked the 8-hour shifts. The only statistically significant finding in this study was that nurses who worked the 12-hour shifts had quicker recovery times than the nurses who worked the 8-hour shifts. The significance value was p = 0.027. Therefore, the 12-hour shift nurses appeared to recover better between shifts because they worked longer hours but fewer days per week. Those working 8-hour shifts could have been affected by additional commute time and days worked. It is also possible working 8-hour shifts would allow time for nurses to take on more personal activities before or after work that could impact between-shift recovery.

Nurse fatigue and shift length continue to be recognized as a source of adverse patient events. This study reflects the increasing emphasis on patient quality and concerns about the impact of health care worker fatigue and efforts of leaders to address patient quality and caregiver satisfaction. Also, it points out that nurse fatigue is complex and may require multiple innovations to address the many contributing factors. Shift length is but one variable that is involved and it is worth noting that nurses are agreeable to try a proposed change in shift length.

Source:

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, scrornin@bellarmine.edu.

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Kentucky Nurses Association
Calendar Of Events 2015

October 2015
7-10 ANCC National Magnet Conference, Atlanta, GA
14 10:30 AM – 5:00 PM Kentucky Board of Nursing Meeting

November 2015
5-8 National Student Nurses Association (NSNA) Mid-Year Conference, Atlanta, Georgia
9 Deadline for the Kentucky Nurse (January/February/March 2016 Issue)
11 Veterans Day - KNA Office Closed
26-27 Thanksgiving Holiday – KNA Office Closed

December 2015
11 10:30 AM – 5:00 PM Kentucky Board of Nursing Meeting
21-31 Christmas 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)

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   - Finding future members
   - KNA-ANA member benefits flyer
   - Sample email you can share with your colleagues

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