Happy Fall! The Kentucky Nurses Association has had a very busy year, and is gearing up now for the annual meeting! Please join us at the Holiday Inn Louisville East, November 3rd and 4th for exciting speakers and presentations titled “The Cutting Edge in Nursing: Issues, Innovations & Opportunities.” Hot topics this year include: School Nurses, Civility, Patient Resilience, Integrative Care, Medication Errors, Resilient Practices, Infections and Community Health Risks.

Some of the KNA activities this past year include:
- A doctoral scholarship which was awarded to a qualified KNA member enrolled in a doctoral program. Candidates who are approved for KNA scholarships work on a project with subject matter related to the KNA platform.
- Active chapters, with educational programs and meetings held across the state. A very active School Nurse Chapter has been very busy and is gearing up now for the annual meeting! Please join us at the Holiday Inn Louisville East, November 3rd and 4th for exciting speakers and presentations titled “The Cutting Edge in Nursing: Issues, Innovations & Opportunities.” Hot topics this year include: School Nurses, Civility, Patient Resilience, Integrative Care, Medication Errors, Resilient Practices, Infections and Community Health Risks.
- Legislative efforts including advocacy for KNA scholarships work on a project with subject matter related to the KNA platform.
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Bluegrass:
KNA Bluegrass Chapter has had a very productive and exciting year! We have Board meetings every third Tuesday of the even months, and membership meetings every third Tuesday of the odd months, both at The Chop House in Lexington starting at 5:30. We arrange for a presentation for membership meetings with the opportunity for attendees to earn 1.0 contact hour. We would love to see you there!

This fall, we will host a Patient Safety and Advocacy Conference on Friday October 21, 7:30 am-12:00 at The Red Mile. Keeneland will be running that day and we hope to have attendees socialize at the races after the conference. We have arranged for four speakers to present and breakfast is included. Cost will be: students $15, members $25, non-members $35. Advanced registration only, and once the races after the conference. We have arranged for four speakers to present and breakfast is included. Cost will be: students $15, members $25, non-members $35. Advanced registration only, and once CEUs are approved and registration opens, more

Green River Chapter:
The KNA Green River Chapter is made up of a diverse group of nurses who believe in the importance of improving patient care and supporting all nurses through continued education opportunities. We have a vested interest in fostering the development of each future nurse by our roles as nurse educators and/or community health nurses within the Green River area of Kentucky.

Contact Person:
Eunice Taylor, MSN, NE-BC
2711 State Route I40E
Utica, KY 42376
E-mail: eunice.taylor@kctcs.edu

Heartland Chapter:
Heartland Chapter meets quarterly in locations around Central Kentucky. This past year we’ve met at libraries, restaurants, and hospitals and are willing to schedule meetings wherever members prefer. We have been exploring ways to increase attendance at meetings through technology as well as assuring we are providing education or meal options as members suggest. We have provided CE offerings and speakers, including State Representative David Floyd and President-Elect Kathy Hager, at our meetings. Several members are currently serving in State elected positions, and others are running for the upcoming election. This has been a great help in keeping our chapter connected and updated to KNA State activities. Due to changes in banking fees and requirements, our chapter’s bank account from dues collected while a District is at risk. KNA and our chapter are looking for options to assure the funds are not slowly depleted by bank charges and fees yet are still readily available to the chapter.

Our chapter now has a Facebook page, email address, and website thanks to the efforts of Anne Sahingoz. We are also working with KNA to develop an easily accessible on line member survey that will provide both the State and the Chapters information on how the association can improve its service to them. Many members find it difficult to attend meetings and stay updated and we are hoping to improve our connection through these communication tools.

KY Nurses Reach Chapter:
The KNA REACH Chapter continues to support KNA’s mission and encourages research, education, advocacy, caring and healing in our local area. The chapter met on four occasions to provide training, networking and continuing education to members and local students. Presentations for our chapter this year included the following:

- On September 22nd, 2015 Matt Travis from KSP/Warren Co. Drug Taskforce presented a one hour CE on “Street Drugs: Recognizing Signs and Symptoms”

Chapter News continued on page 4

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- Recovery Room (Job ID # 2179)
- ICU (Job ID # 293, 1279, 2956, 3500)
- OB/L&D (Job ID # 392, 1790)
- Outpatient (Job ID # 593, 598, 3489)
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To apply please visit phs.org/careers.
**Chapter News continued from page 3**

- On November 3rd, 2015 Dr. Randall Hansbrough presented a one hour CE on Asystole.
- On February 16th, 2016 Melissa Gilpin presented a one hour CE on Human Trafficking.
- On April 19th, 2016 Ashley Lindsey presented a one hour CE on Interpretation of 12 Lead EKGs.

Chapter members collected items for non-profit organizations at meetings. Donations were made to Barrren River Area Safe Space, Toys for Tots and other local agencies. Chapter members also sold CPR pens to raise funds for the chapter and worked on developing a membership scholarship for new graduates. The KNA REACH Chapter will hold meetings in September/November 2016 and February/April 2017. Local nurses and students are invited to attend meetings. If interested in attending, please contact Kim Bourne (kim.bourne@wku.edu) or Dawn Garrett Wright (dawn.garrett@wku.edu).

**Nightingale Chapter**

> Our Chapter was formed in 2014. The previous officers had been in place 2 years, therefore the process of reorganizing, reviewing its objectives and the chapter to attend meetings. The chapter is in the Association.

> Currently, the Chapter has 74 members.

> A scholarship was given to a graduating nursing student.

> Efforts have been made to encourage members of the chapter to attend meetings. The chapter is in the process of reorganizing, reviewing its objectives and seeking a new chair.

> JoAnn M. Wever
> Chair

**Northern Kentucky Chapter**

> The Northern KY Chapter has completed the Substance Use Disorder education. This education was presented at the “Surviving Your First Year” event held in Bowling Green in April by Carla Hamilton. Presentations of this education have been modified/presented to the St. Elizabeth HealthCare’s Journal Club and at St. Mary’s Church in Alexandria.

> Substance Use continues to rise and education is valuable related to this terrible disease. The Chapter looks forward to new opportunities and membership.

**River City Chapter**

> The River City Chapter hosted a continuing education event related to Human Trafficking on August 1st. The program focused on empowering nurses to help victims of human trafficking by recognizing symptoms of a trafficked individual and how to care for such individuals. One woman who was rescued from human trafficking spoke of her recovery. Guest speakers included Rabbi Dr. Nadia Sirtsky, MSSW, BCC, Director, Human Trafficking, Alliance; Rhonda Lee Corbet, MSN, APRN, FNPs-BC; Marissa Castellanos, MSSW. It was well attended.

> The chapter has met several times this year for brain storming about possible activities and community projects. Membership is encouraged to be involved in a volunteer project, not only for self-development but to put a face on RNA in the community.

> The chapter continues to seek new leadership after the resignation of president Charolette Rock and treasurer Paulette Adams. They continue to be looking for new graduates. The KNA REACH Chapter Board for 2016-2018: Chair - Kim Bourne, Treasurer - Carol Evans, Secretary - Dawn Garrett Wright.
Calendar of Events

September 2016

5 Labor Day Holiday – KNA Office Closed
13 5:00 PM CST KY REACH Chapter Meeting
   WKU/Medical Center Health Sciences Complex, Bowling Green
16 KNA Board of Directors Meeting
16 Deadline for Evidence Based Practice Abstracts
20 5:30 PM Bluegrass Chapter Meeting
   Chop House on Richmond Road, Lexington
30-2nd KANS Conference

October 2016

21 8:00 AM - 12:00 PM; Registration starts at 7:30 AM. Bluegrass
   Chapter Patient Safety and Advocacy Conference

November 2016

3-4 Convention 2016, The Cutting Edge in Nursing: Issues,
   Opportunities, and Innovations
   1325 Hurstbourne Parkway, Louisville, KY
7 Deadline for the Kentucky Nurse
9 6:00 PM Northern KY Chapter Meeting, St. Elizabeth Healthcare
   in Edgewood, Kentucky Room M (6th floor)
11 Veterans Day – KNA Office Closed
15 5:30 PM Bluegrass Chapter Meeting
   Chop House on Richmond Road, Lexington
24-25 Thanksgiving Holiday – KNA Office Closed
29 5:00 PM CST KY REACH Chapter Meeting
   Greenview Regional Hospital, Bowling Green

December 2016

20-3rd Christmas Holiday – KNA Office Closed

February 2017

21 5:00 PM CST KY REACH Chapter Meeting
   WKU/Medical Center Health Sciences Complex, Bowling Green

April 2017

18 5:00 PM CST KY REACH Chapter Meeting
   WKU/Medical Center Health Sciences Complex, Bowling Green
19-22 Kentucky Coalition of Nurse Practitioners & Nurse Midwives
   Annual Conference
   Covington, Kentucky

April 2018

16-21 Kentucky Coalition of Nurse Practitioners & Nurse Midwives
   Annual Conference
   Lexington, Kentucky

April 2019

22-27 Kentucky Coalition of Nurse Practitioners & Nurse Midwives
   Annual Conference
   Covington, Kentucky

***All members are invited to attend KNA Board of Directors meetings.
Please call the KNA office first to assure seating, meeting location, time and date.

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<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterling silver</td>
<td>14k gold remold over sterling silver</td>
<td>Sterling silver with a 14k gold heart</td>
</tr>
<tr>
<td>Cost</td>
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<td>$100.00</td>
</tr>
<tr>
<td>LEOS 25%</td>
<td>-19.25</td>
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<tr>
<td>Tax</td>
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<td>$4.50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$64.22</td>
<td>$79.50</td>
</tr>
</tbody>
</table>

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Kentucky Nurse  •  Page 5
The number of total knee arthroplasties (TKA) and total hip arthroplasties (THA) will dramatically increase over the next 15 years because of the aging population. Post-operative pain control is one of the quality control metrics under the Patient Protection and Affordable Care Act affecting reimbursement. Pain control is also a significant source of patient fear related to THA and TKA. Health care providers use continuous peripheral nerve blocks (CPNB), because they offer greater pain control and fewer systemic side effects than opioid analgesics. CPNB are an attractive pain control protocol, because they are associated with a reduced length of stay. However, CPNB are also associated with an increased risk of falls.

An interdisciplinary research group at the University of San Diego set out to study whether CPNB are associated with an increased the risk of falls for hospitalized THA and TKA patients. Their review of literature showed only six articles published on the topic from 2008-2014. Those studies showed a positive correlation between risk of falls in TKA and THA patients and use of CPNB. The researchers, however, queried whether this relationship was due to selection bias in participant selection and assignment of participants to the treatment or control groups. Accordingly, the researchers chose a retrospective cohort study to eliminate the issue of selection bias.

The retrospective cohort study was done at an academic hospital with a diverse patient population in southern California. The researchers compared fall rates from before and after CPNB were initiated at that hospital. They compared fall rates for THA and TKA patients to hospital wide fall rates. They then used data from the hospital's quality control records to determine the circumstances of the falls for the TKA and TKA patients.

The results of this study indicated a strong positive correlation between use of CPNB and the likelihood of a patient falling. Before CPNB were implemented, there were no reported falls of patients who underwent TKA/THA. After CPNB, between 2007 and 2010, falls involving patients recovering from TKA/THA made up an average of 3.6 percent of the 1,041 recorded falls in the hospital, for a total of 37 falls. This is compared to no falls prior to CPNB. These results are statistically significant (p=.0001), that is, they are most likely not due to chance. These results are also not likely a result of improved reporting procedures since hundreds of falls were reported prior to the implementation of CPNB, but none involved patients who underwent TKA/THA. One statistic that should be noted is that of the 37 reported falls, only 2 were in the presence of nursing staff. Since the vast majority of falls occurred when the patient was alone, future research could be conducted that investigates whether or not the patient had pressed the call light, and how long the patient waited before attempting to stand without assistance.

Patient falls can result in serious injury, as well as reducing hospital reimbursements and increasing litigation risk. It is important that as new treatments emerge that may increase the risks of falls, nursing staff, patients, and their families need to be thoroughly educated regarding the absolute need for the patient to be assisted out of bed. Prompt response to bed alarms and call lights, as well as perhaps more frequent rounding for those patients identified as very high risk for falls, should become common practice for nurses when caring for patients on CPNB.

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.
Nursing and the LGBT Community in Kentucky

Nancy Elaine Rimas, BSN, RN-BC, SCRN
Lake Cumberland Regional Hospital
Somerset, Kentucky

Professional nurses have been described as the front-line of healthcare, promoting respectful interactions with a diverse population of patients. These nursing interactions and interventions consider cultural, spiritual, and socioeconomic factors aligned to the patients and their families. When patient care is provided in a culturally competent and respectful manner, the potential exists to improve the quality of care and outcomes for all patients (United States Department of Health and Human Services, 2003). The Lesbian, Gay, Bisexual, and Transgender (LGBT) population of Kentucky has unique healthcare needs for the professional nurse to consider when planning care.

Established in 2001 at the University of California, Los Angeles (UCLA) School of Law, The Williams Institute produces independent research that focuses on public policy and law as it relates to gender issues and the LGBT community. The Williams Institute compiled data from the 2010 census, reporting 132,000 Lesbian, Gay, Bisexual and Transgender (LGBT) adults in the Commonwealth of Kentucky (Mallory, Flores, & Sears, 2016). Respected sources such as the Gay and Lesbian Medical Association (GLMA), the Human Rights Campaign (HRC), and The Joint Commission (TJC) all agree that this population faces significant factors aligned to the patients and their families (GLMA, 2006). The Lesbian, Gay, Bisexual, and Transgender (LGBT) community faces barriers to healthcare access that include denial of services, harassment, and rough handling during treatment (Stroumsa, 2014). The Human Rights Campaign [HRC(2016) reported that 70% of LGBT patients described encountering some form of discrimination or harassment when seeking healthcare. Research also demonstrates the LGBT community has higher risks for tobacco use, substance abuse, alcoholism, anxiety, depression, and sexually transmitted diseases (TJC, 2011). The persistence of barriers to receiving care has a negative impact on the LGBT community, which can lead to individuals avoiding routine or preventive care (Cicero & Black, 2016). Developing equitable, knowledgeable care and ensuring access to that care has immediate and long-term implications for the health and safety of the LGBT community.

In 2016, HRC published their ninth report rating healthcare facilities across the nation on LGBT policy and practice. HRC developed the Healthcare Equality Index (HEI) outlining four essential components that demonstrate a commitment to inclusion and equality for care of the LGBT community. The four components of the HEI are: patient non-discrimination, equal visitation, employee non-discrimination, and staff training. When these components are established, a facility may be designated as a ‘Leader in LGBT Healthcare Equality’ (HRC, 2016). The HEI program provides hospitals with viable documentation supporting TJC standards prohibiting discrimination based on sexual orientation and/or gender identity (HRC, 2016). The HEI program also facilitates compliance with federal mandates that prohibit sex stereotyping and gender identity discrimination (HRC, 2016).

Conclusions
Kentucky healthcare professionals need to seek authoritative information on developing LGBT inclusive policies. A first step is to become familiar with the language and vocabulary of the LGBT population. Next, reviewing the recommendations of respected resources (TJC, HRC, GLMA, etc.) is needed to develop a knowledge-base of best practices for creating an inclusive, respectful environment. Then, taking this knowledge and becoming an active participant in policy planning and advocating for LGBT also is needed. The professional nurse has many opportunities to participate in this process and should understand that advocacy for the LGBT community is not only ethical, but is an opportunity to positively impact patient outcomes.

References


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Eva Stone, MSN, APRN
Lincoln County School System, Stanford, Kentucky

Kentucky has led the nation in negative health outcomes for many years. According to America’s Health Rankings the state rates 44th in overall health based on prevalence of adult obesity, smoking, diabetes and physical inactivity (United Health Foundation, 2015). Although many programs have been implemented across the Commonwealth in an effort to curb these trends, there are few comprehensive processes in place to prevent children from following the same trajectory. According to the most recent Kids Count Data, 15% of children are not in excellent or very good health (Annie Casey Foundation, 2016b) and 36% of 10-17 year olds are overweight or obese (Annie Casey Foundation 2016a). Student health data reported by schools across Kentucky shows that preventive care is lacking among youth and that nearly 77,000 children with asthma, life-threatening allergies, diabetes and seizures attend public school each day (Kentucky Department of Education, 2016b). Unfortunately, there is no state data base which reports how districts prepare to meet these needs and if they are equipped to respond to the health needs of children. While Kentucky has legislation which allows students to carry asthma inhalers, and requires staff to trained to administer epinephrine for those children with prescriptions, there is no legislation requiring schools to stock rescue asthma medications or epinephrine. Of 225 respondents to a survey of school districts regarding school nursing services, 68.35% reported that their district did not have protocols to keep and administer “stock” epinephrine at school (Stone, 2013). State health reports from 2014-2015 showed that 2.9% of parents reported children having significant food allergies; 7.1% with asthma; 0.3% with diabetes; and 0.75% as having seizure disorders. These same data showed that despite requirements for physical examinations and immunizations in kindergarten and sixth grade, only 86.3% of kindergarteners and 73.6 % of sixth graders met those prerequisites. Statewide, 8.1% of these children were not fully immunized and thus at risk of contracting or transmitting communicable diseases (Kentucky Department of Education, 2016b). Risks for untoward events related to health conditions, failure to complete health examinations, risk of communicable disease, and lack of a coordinated effort to prevent chronic conditions, are all red flags surrounding the care of children in Kentucky.

Unfortunately, the state does not require capital funding for nurses in schools. Without legislative mandates for nurses they are often the first positions eliminated when budgets are cut. And when nurses are not present, the risk of illness or injury increases. In 2012 a first grade student in Virginia ate a peanut given to her from another student on a school playground (Landau, 2012). Due to a severe peanut allergy, she had an anaphylactic reaction and died by the time EMS arrived at school. In 2014, a 12 year old in Philadelphia died after having an asthma attack at a school where nurses had been reduced by budget cuts (Superville & Blad, 2014). Also, in Philadelphia, a seven-year-old boy collapsed and died at a school that had no nurse on duty (Lee, 2014). With 11.1% of children enrolled in Kentucky schools reporting serious allergies, asthma, diabetes and epilepsy (Kentucky Department of Education 2016b) and no state requirement to have nurses present in the schools, it seems that the lives of children are risked each day.

School health services have been described as a “hidden system of health care” by Lear, founder of the Center for Health and Healthcare in Schools at the George Washington University School of Public Health and Health Services (Robert Wood Johnson Foundation, 2010). School nurses are at the core of school health services. They collaborate with other health professionals to serve the needs of all students. They provide care for acute illness and injury, manage chronic health conditions, prevent and track communicable diseases, engage families in health promotion, provide care for children with disabilities and intensive medical needs, handle medical emergencies and connect children with health insurance and health care providers (Robert Wood Johnson Foundation, 2010). Roughly 680,000 children attend public schools in Kentucky every day (Kentucky Department of Education, 2016b). Imagine how health outcomes in Kentucky might change if every child has access to a school nurse. Children with chronic health conditions will be safer at school, systems can be implemented to address children’s health in a comprehensive fashion and Kentucky can move toward a healthier population.

WHAT CAN BE DONE?

Kentuckians should be concerned for the children attending schools and for the future of the Commonwealth. That concern should then lead Kentucky toward action. Each and every Kentuckian should:

1. Look at data for the community. A summary of reported health conditions for school children in your area can be found on a site called Open House provided by the Kentucky Department of Health and Human Resources.

2. Contact your state representative and ask them to support legislation that requires school nurses in Kentucky schools.

3. Support local schools and school districts that have nurses.

4. Vote for candidates who support school nursing services.

5. Be sure to raise the issue of school nursing with your friends and neighbors.

6. Join the Kentucky State Nurses Association and support their efforts to increase funding for school nursing services.

7. Contact your local school district and ask about the status of school nursing services in your area.

8. Support the Kentucky Department of Education’s efforts to increase funding for school nursing services.

9. Support the efforts of the Kentucky Department of Health and Family Services to increase funding for school nursing services.

10. Be sure to talk to your children’s school nurse about the importance of school nursing services.

Unhealthy Children Equals an Unhealthy Commonwealth: The Need for School Nurses

Continued on page 14

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According to a study by the Centers for Disease Control and Prevention (CDC, 2016), one in 25 hospital patients has at least one Healthcare-Associated Infection (HAI) (AHRQ, 2015). Furthermore, five to ten percent of patients admitted to acute care facilities in the United States (U.S.) develop a HAI during their inpatient stay (CDC, n.d.; Johnson, Lineweaver, & Maze, 2009). The costs associated with HAIs are astronomical and are not reimbursed by Medicare and Medicaid if deemed to be preventable (HHS, 2008). The CDC (n.d.) reported the current cost of HAIs as being close to 20 billion dollars in the U.S. alone. Therefore, it is economically advantageous for health care facilities to identify and prevent HAIs.

The use of hospital equipment and various treatment regimens have been linked to HAI (Elpern, Killeen, Ketchem, Wiley, Patel, & Lateef, 2009; Madeo & Lowry, 2011; Venkatram, Rachmale, & Kanna, 2010). Johnson et al. (2009) reported that little information is known about the potential sources of infection from personal patient items like bath basins and recommended increased awareness of bath basins as a source of HAI. National guidelines to minimize bacterial contamination includes cleaning and disinfecting wash basins routinely using an Environmental Protection Agency (EPA) approved product (CDC, 2003). In a study by Johnson et al. (2009), 98% of all bath basins sampled in a multisite study were contaminated with bacteria. Microorganisms found in the bath basins included Enterococci (54%), Gram negative organisms (32%), S aureus (23%), Vancomycin-resistant enterococci (13%), Methicillin-resistant S aureus (8%), P aeruginosa (5%), C albicans (3%), and E coli (2%).
Table 1. Bath Basin Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are bath basins labeled for bathing use?</td>
<td>4 (15.38)</td>
<td>21 (80.77)</td>
</tr>
<tr>
<td>Is tap water used for bath basin water?</td>
<td>23 (88.46)</td>
<td>3 (11.54)</td>
</tr>
<tr>
<td>Is any type of antiseptic used in the bathing water?</td>
<td>8 (30.77)</td>
<td>18 (69.23)</td>
</tr>
<tr>
<td>Are disposable washcloths used for bath basin bathing?</td>
<td>2 (7.69)</td>
<td>24 (92.31)</td>
</tr>
<tr>
<td>Are there standardized procedures for cleaning bath basins?</td>
<td>3 (11.54)</td>
<td>22 (84.61)</td>
</tr>
<tr>
<td>How are bath basins handled after completion of bathing? (Answer all that apply.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wiped with a paper towel to eliminate standing water</td>
<td>13 (50)</td>
<td></td>
</tr>
<tr>
<td>Placed upside down on a storage table to air dry</td>
<td>5 (19.23)</td>
<td></td>
</tr>
<tr>
<td>Wiped with the wash cloth and allowed to air dry</td>
<td>4 (15.38)</td>
<td></td>
</tr>
<tr>
<td>Placed in patient restroom</td>
<td>6 (23.08)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11 (42.31)</td>
<td></td>
</tr>
<tr>
<td>Rinsed at sink</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placed in bedside table</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinfected with Dispatch® &amp; allowed to air dry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placed in bag for storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discarded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there standardized procedures for storage of bath basins after completion of bathing?</td>
<td>6 (23.08)</td>
<td>20 (76.92)</td>
</tr>
<tr>
<td>Are bathing supplies placed in bath basin used for patient bathing?</td>
<td>16 (61.54)</td>
<td>9 (34.61)</td>
</tr>
<tr>
<td>Are bath basins discarded after a certain period of time?</td>
<td>7 (26.92)</td>
<td>19 (73.08)</td>
</tr>
</tbody>
</table>

N=26, missing=1

Studies on bathing protocols for patients to prevent HAIs have mixed results. A study by Noto et al. (2015) found that daily bathing of patients with 2% chlorhexidine did not reduce the occurrence of HAIs in a sample of over 9,000 ICU patients at a large medical center in Tennessee. In contrast, Climo et al. (2013) found in a multisite study of hospitalized patients that the use of chlorhexidine impregnated cloths reduced the rate of multidrug resistant organism HAIs by 23%.

Since HAIs are a burden to patients, their families and communities, and society and due to the limited studies on HAI and bathing protocols, the purpose of this pilot study was to 1) examine the bathing procedures for patients in both acute and long term care facilities in Kentucky, and 2) describe the procedures used by facilities for labeling, cleaning and disposing of reusable bath basins.

**Methods**

This descriptive study was performed by electronically surveying acute care and long term care facilities in Kentucky. The pilot study was approved through the university’s Institutional Review Board. The team of researchers developed a questionnaire based on their years of experience using bath basins and providing patient baths while practicing as acute and critical care nurses. This 17-item survey consisted of a single demographic item while the remaining items assessed procedures.
for patient bathing and protocols for handling bath basins. Each question was entered into Qualtrics, an electronic surveying tool, to enable electronic distribution and collection of responses throughout the state. Members of the Kentucky Hospital Association (N=120) and the Kentucky Association of Health Care Facilities (N=200) received a brief email welcoming them to participate in the study and containing the link which opened the anonymous survey. Completion of the survey implied consent, after which the respondents had the option of being entered into an anonymous drawing for one of five $50.00 VISA gift cards. Data collected in Qualtrics were analyzed using descriptive statistics and review of responses to open response items. IBM SPSS 23 software was used for this analysis.

Results
Twenty-six facilities participated in the pilot study and the majority (77%) of these provided acute care patient services. Eighteen (69%) of the respondents indicated that disposable bath basins were used in patient care, and only 11 (44%) noted that standardized patient bathing procedures were used. Procedures for patient bathing ranged from bathing in bathrooms to bathing with disposable basins. In addition, facilities used chlorhexidine gluconate (CHG) wipes such as Bath in a Bag® systems or disposable bath wipes. Some healthcare sites specified certain procedures for bathing patients based on the patient’s diagnosis and/or the unit upon which they were admitted. Critical care patients were cleansed with CHG soap and/or bathed with chlorhexidine while Open Heart patients received a bath with Hibiclens®. One location indicated that the bathing technique varied by the caregiver.

Fourteen (52%) facilities noted that patient bathing begins on the morning after admission. In addition, eleven (44%) facilities specified patient bathing occurred at other times also described as 1) as needed, 2) within 24 hours of admission, 3) upon patient request, 4) post op day one, or 5) patient condition or need for bath when admitted. Respondents noted that most patients were bathed daily and as needed unless the patient was geriatric in which daily bathing is contraindicated. The findings related to bath basins procedures are found in Table 1.

Discussion and Implications for Practice
This pilot study was conducted to determine current practices related to patient bathing procedures and handling of bath basins. The participating facilities in Kentucky overwhelmingly indicated that standardized procedures are not developed and/or followed for either. An exception appears to be in some critical care units where respondents noted the use of disposable basins and CHG.

A review of the literature shows little standardization in the practices for bathing patients. According to the CDC (2003), use of chlorhexidine in patient bathing to prevent central line-associated bloodstream infections (CLABSSIs) outside ICUs and to prevent MRSA infections is recommended. In its guidelines for environmental infection control, the CDC recommended that bath basins be cleaned and disinfected frequently with an EPA approved product. Furthermore, the guideline referenced the draining and cleaning of tubs and whirlpools after each patient’s use and disinfecting equipment surfaces and components with an EPA approved product (CDC, 2012). Based on the findings of this pilot study it is evident that protocols for bathing and using bath basins should be developed and implemented in the state of Kentucky. Each facility should have a specific bathing protocol in place based on evidence based recommendations.

Limitations
Findings from this pilot study are limited in their generalizability. The authors note that the study was conducted in only one southeastern state and other bathing procedures may be common in various parts of the U.S. In addition, the study response rate was low at 17% for acute care hospitals and 3% for long term care facilities, which is common for survey based research. Furthermore, the survey was sent to the Chief Nursing Officer or Administrator at each facility and it is unknown if the recipient completed the questionnaire or had another individual provide the information. Finally, the use of a researcher developed tool is a limitation of this study. Based on the results of this pilot study and its limitations, the researchers are currently planning a national study using a validated questionnaire very similar to the questionnaire used in this study to further assess bathing procedures and bath basin use in the U.S.

Conclusion
The results of this pilot study demonstrate that bathing procedures and the use of bath basins vary across Kentucky. A review of the literature shows that the lack of standardization is likely not an isolated problem and may impact patients across the country. Given that bathing is a procedure that affects every patient admitted in both acute and long care facilities, future research and development of standard procedures are crucial to prevent HAIs, patient suffering and tremendous cost to an already financially strained healthcare system.

References


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 part of your community, family and neighbors when they need it most.
American Nurses Association President Named to “100 Most Influential People in Healthcare” List

For the second consecutive year, ANA President Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN, has been named one of Modern Healthcare’s “100 Most Influential People in Healthcare.” This awards and recognition program honors individuals in health care who are deemed by their peers and an expert panel to be the most influential individuals in the field. In addition to her appearance on last year’s “Most influential” list, Dr. Cipriano has also been recognized as one of Modern Healthcare’s “Top 25 Women in Healthcare.”

In the past year, Dr. Cipriano has spoken about putting more nurses in leadership roles and supporting the Department of Veterans Affairs’ efforts to provide direct care to veterans by allowing APRNs to practice to the full extent of their education and training.

The “100 Most Influential People in Healthcare” honorees come from all sectors of health care, including hospitals, health systems, physician organizations, insurance, government, vendors and suppliers, trade and professional organizations, and patients’ rights groups. Dr. Cipriano and fellow honorees are currently highlighted in the August 22 print edition of Modern Healthcare and online at ModernHealthcare.com.

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Nursing Coalition Praises Commission on Care
Recommendations to Improve Veterans’ Healthcare

APRNs, RNs looking forward to being part of solution to improve access to timely care.

WASHINGTON, D.C. – Advanced practice registered nurses (APRNs) and other registered nurses (RNs) in the Veterans Health Administration (VHA) stand ready to be part of the solution to improve veterans’ access to timely, quality healthcare by working to their full practice authority as recommended by the Commission on Care in a report to the White House on July 5, said Juan Quintana, DNP, MHS, CRNA, president of the American Association of Nurse Anesthetists (AANA).

The commission, established as part of the Veterans Access, Choice, and Accountability Act of 2014, was charged with examining veterans’ access to VHA healthcare and determining how best to deliver healthcare to veterans during the next 20 years. The 308-page report was the culmination of an exhaustive 10-month assessment by the commission.

Speaking on behalf of a Nursing Coalition which endorses direct access to APRNs including Certified Nurse Practitioners (CNPs), Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNMs), and Clinical Nurse Specialists (CNS), Quintana said that allowing all VA APRNs to practice to the full scope of their education and abilities without physician supervision would improve veterans’ access to essential healthcare by reducing long wait times for appointments and services.

The commission’s recommendation supports a Veterans Administration (VA) proposal to grant direct access to VA APRNs that was published in the Federal Register on May 25; comments on the rule are being accepted by the VA until July 25. With less than two weeks to go, more than 62,000 comments have been received from veterans, healthcare professionals, and the general public, mostly in favor of the rule.

“The evidence cannot be denied,” said Quintana. “The commission’s final report adds more data to the growing stack of evidence highlighting the need to allow all APRNs to have full practice authority as recommended by the Commission on Care for its support of full practice authority for advanced practice registered nurses in the VHA,” said Maureen Swick, RN, MSN, PhD, NEA-BC, AONE executive officer/American Hospital Association senior vice president, Nursing. “APRNs are a vital link to ensuring quality care is readily accessible for America’s veterans.”

“The clinical evidence and informed recommendations that patient care is improved by direct access to APRNs continue to grow,” said Cindy Cooke, DNP, FNP-C, FAANP, president of the American Association of Nurse Practitioners (AANP). “Veterans, the AANP, other APRN groups, the VA, and now an independent congressional commission on the VHA all agree that the VAs highly-qualified APRNs, including 4,800 nurse practitioners who provide a wide range of healthcare services, are the right solution to ensuring veterans have access to timely, quality healthcare.”

American Nurses Association (ANA) Chief Executive Officer Marla Weston, PhD, RN, FAAN, who previously served in the VHA as program director in the Office of Nursing Services and then as deputy chief officer in the VA Workforce Management and Consulting Office, praised the commission’s recommendations on clinical operations.

“The commission’s recommendation that clinical operations should be enhanced through more effective use of health professionals – particularly optimizing use of advanced practice registered nurses – along with improved data collection and management, is right on target,” said Weston. “The commission’s recommendation is consistent with the recommendations of the National Academy of Sciences to remove scope-of-practice barriers and allow the VA to fully utilize the skills of its APRNs to the full extent of their education, training, and certification.”

The American Association of Colleges of Nursing (AACN) commended the commission for recognizing that the way in which APRN students are educated must align with how they practice to achieve the best patient outcomes. “The Commission on Care should be applauded for its steadfast work to advance recommendations based on the evidence,” said Juliann Sebastian, PhD, RN, FAAN, chair of the AACN Board of Directors. “For our nation’s Veterans to receive the care they need, when they need it, we must look to the decades of data that show APRNs excel in providing high quality care when practice barriers are removed.”

The VA’s proposed policy to allow direct access to APRNs in order to improve veterans’ access to timely healthcare is supported by veterans groups such as AMVETS, Paralyzed Veterans of America, Military Officers Association of America, and Air Force Sergeants Association; AARP (whose membership includes 3.7 million veteran households); numerous healthcare professional organizations; and more than 80 Democratic and Republican members of Congress.

Comments on the proposed rule can be submitted at www.regulations.gov/document?D=VA-2016-VHA-0013-0001

Coalition Members
For more information about the coalition members, visit:

American Association of Colleges of Nursing (www.aacn.nche.edu)
American Association of Nurse Anesthetists (www.aana.com)
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Unhealthy Children Equals an Unhealthy Commonwealth continued from page 8

Department of Education at http://openhouse.education.ky.gov. Click on the “Supplemental Data” tab at the top of the page. Click on the “Student Health” tab, scroll down and open the link labeled “Student Health Data.” Aggregate student health information is available by county. Advocates should be aware of what local data show and where gaps/consensus exist.

2. Ask if and how schools in the area are currently staffed with nurses. The name of the local School Health Coordinator can be found by going to http://openhouse.education.ky.gov and clicking on “Kentucky Schools and Districts.” The name of the district Health Coordinator will be listed under “district contacts.” He/she would likely be glad to discuss the health of children in the district, as these are worries being faced by coordinators around the state.

3. Get involved! The Kentucky Nurses Association has developed a chapter “A Nurse for Every Kentucky School.” Advocates are welcome to be part of this group. Email Mary Burch (mary.burch@erlanger.kyschools.us) or Eva Stone (eva.stone@iprsc.kyschools.us) to add them to the distribution list. Those interested in taking part can learn more about the work underway to present legislation requiring nurses in all of Kentucky’s schools.

4. Like the chapter Facebook page at: https://www.facebook.com/A-Nurse-For-Every-KY-School-391170095092044/ and share this page with parents of school aged children or others who may be interested in advocating for children’s health. This page will be used as a means of communication with advocates around the state.

Summary
There is power in numbers and nurses are an influential group. Supporters cannot continue to wait on solutions that have not come. Nurses are powerful change agents and it is time to push for change! This change should be a nurse in every school in Kentucky for the health, safety and education of children.

References
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KNA Centennial Video
Lest We Forget Kentucky’s POW Nurses

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

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