As I write this article, the KNA Board of Directors has just determined a course for the KNA that could redefine the future of the KNA for all of its members. The recent action by the Board could resolve the uneasiness over unionism that has existed in the KNA since our first union was organized. There has long been uncertainty among some of the over two-thirds of our membership who are not union about whether unionism is professional and a smart affiliation for the KNA, while there has been equal uncertainty at times on the part of our union leadership about whether the KNA serves its union members well enough. For decades, these two perspectives have co-existed under a strain that was negligible some years, and divisive other years. But at the end of February, the KNA Board of Directors was presented with an opportunity that, if successful, will provide a win-win for union and non-union members of KNA.

In a nutshell, the KNA Collective Bargaining Division (CBD), with the support of the national union, the UAN, proposed that the KNA petition the National Labor Relations Board to amend its certification of the KNA to the CBD as its own independent organization separate from the KNA. This proposal came in the midst of disagreement between the CBD and the KNA Board of Directors about KNA’s future with the national union (the UAN) and the membership vote to determine whether the KNA remained a member of the UAN. The procedure to accomplish this is called an “AC Petition”.

If the National Labor Relations Board approves the AC Petition, the CBD would leave the KNA and become an independent union. The CBD now functions very much on its own with very little oversight by the Board of Directors. It would continue to do so. CBD could then affiliate with any organization it chooses, without impacting the KNA or its non-union membership. In turn, KNA will no longer be exposed to the possibility of affiliations with national unions whose organizing strategies and agendas conflict with the philosophies of many KNA members. In addition, the finances of the KNA will no longer be subject to the abuses of union busting tactics and we will be able to stabilize our budget over time, while the union nurses will continue to have financial support from an organization larger than the CBD. That stability will make the KNA a stronger, better association.

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LaTonia Denise Wright
RN, BSN, JD
The KNA has been working for decades to provide services to RNs to help them navigate workplace concerns. Sometimes those “concerns” are practice and license issues, while other times they relate to workplace conflict or employment issues.

As time goes by, RNs are finding that law and regulation has a direct impact on their lives and that having a resource like KNA can be invaluable when those issues arise. Now KNA membership has become even more valuable to those RNs who have workplace problems of any kind.

LaTonia Denise Wright is a nurse attorney with a distinguished career in nursing and law. Ms. Wright lives just outside of Cincinnati and practices law in Kentucky, Ohio and Indiana. She left a job at a large law firm representing doctors, dentists, and others so that she could focus her practice on helping nurses. And now she is working with the Kentucky Nurses Association in order to reach more nurses in need of help.

If you are a KNA member in need of legal advice or representation, Ms. Wright will discount her legal fees for you. But membership is required at the time you call. Of course, all RNs in need should contact Ms. Wright, but KNA membership will make that call more affordable.

LaTonia will also be a contributor to the KY NURSE and will offer insights into some of the most common legal concerns that nurses face. In addition, the KNA website (www.kentucky-nurses.org) has a link to her website and blog so that you can contact her directly.

See LaTonia’s article on page 6.
INFORMATION FOR AUTHORS

- Kentucky Nurse Editorial Board welcomes submission articles to be reviewed and considered for publication in Kentucky Nurse.
- Articles may be submitted in one of these categories:
  - Personal opinion/experience, anecdotal (Editorial Review)
  - Research/scholarship, clinical, professional issue (Class: Peer Review)
- Research Review (Editorial Review)
- All articles, except research abstracts, must be accompanied by a signed Kentucky Nurse transfer of copyright form (available from KNA office) when submitted for review.
- Articles will be reviewed only if accompanied by the signed transfer of copyright form and will be considered for publication on condition that they are submitted solely to the Kentucky Nurse.
- Articles should be typewritten with double spacing on one side of 8 1/2 x 11 inch white paper and submitted in triplicate. Maximum length is five (5) typewritten pages.
- Articles should also be submitted on an IBM compatible 3.5” computer disk in Word Perfect or Microsoft Word.
- Articles should include a cover page with the author’s name(s), title(s), affiliation(s), and complete address.
- Monetary payment is not provided for articles.
- Receipt of articles will be acknowledged by a letter to the author(s).
- Following review, the author(s) will be notified of acceptance or rejection. Manuscripts that are not used will be returned if accompanied by a self-addressed stamped envelope.
- The Kentucky Nurse editors reserve the right to make final editorial changes to meet publication deadlines.
- Articles should be mailed to:
  Editor, Kentucky Nurse
  Kentucky Nurses Association
  1400 South First Street
  PO Box 2619
  Louisville, KY 40201-2616
  (502) 637-2546
  or email: Contact@Kentucky-Nurses.org

President’s Pen (continued from page 1)

KNA staff and leadership better able to pursue the diverse needs and interests of all its members, including practice concerns, workforce advocacy, continuing education, legislation and regulation, and much more. The union nurses will continue to have virtually the same representation through the same venues as they presently have.

After lengthy discussion with KNA’s labor attorney, Buddy Cutler, the Board of Directors felt that the pursuit of the AC Petitions was in the best interest of the CBD and the KNA. They voted to honor the request of the CBD leadership and to proceed with the AC Petition Process. The Board took this decision very seriously because, if successful, it will result in the departure of just over five hundred KNA members, as serious because, if successful, it will result in the termination of KNA’s membership in the UAN. The Board of Directors is committed to honoring the membership vote on affiliation with the UAN, if and when that vote is needed. But the proposal of the AC Petition Board provided a window of opportunity that the Board believes offered a rare chance to address the needs of all members, even if that means that the CBD and KNA part ways. For the Board, this development was important enough to suspend the counting of ballots in exchange for a possible win-win.

It is possible that the outcome of the AC Petitions will be known at the time this edition of the KY NURSE is distributed. Attorneys explained that the process can take two months without delays, longer with delays. While there is no way to predict timing or outcome, legal counsel believes that success is likely and hopes that the process will take no more than two months. If that is the case, we will have resolution before May 2008. Check the KNA website for updates.

The KNA Board of Directors has taken a bold step, in coordination with the CBD leadership to chart a positive future for all members of the KNA and to free both groups to pursue their priorities. If successful, this action will redefine the KNA, which will be historic for the nurses of Kentucky.
Once again, the KNA’s annual Legislative Day proved to be a terrific success. The program was attended by nearly five hundred nursing students and nurses from across the state and the line up of speakers and panelists was outstanding.

KNA’s lobbyist, Dr. Sheila Schuster, led attendees through a series of sessions that introduced the audience to a range of lawmakers, policy makers and Kentucky’s Attorney General Jack Conway. The audience had the opportunity to interact with Dr. Schuster and our speakers and panelists with an open forum for questions and comments during each session. (Next year a better microphone system is promised to enhance that experience even more.)

The backdrop of the event was provided by Sheila Schuster who taught the basics about the legislative process, the political climate, and provided insights from her decades of experience as a lobbyist in Frankfort. KNA member and State Representative Mary Lou Marzian, RN came for a visit and discussed her expectations for the 2008 Legislative Session and the impact on nursing and health care. Rep. Marzian was candid in her descriptions of the 2008 political landscape and how she thought it would affect patient care and the nursing profession. She emphasized that nursing participation in the political process is essential to protecting quality care and nursing practice and she urged the audience to be active in following legislation and expressing their opinions to their elected officials.

Dr. Maggie Miller, the Chairperson of the KNA Governmental Affairs Cabinet, moderated a panel discussion that opened conversation about legislators’ expectations for the session and their insights about how to approach nursing concerns in the legislature. A lively discussion took place over staffing issues, whistleblower concerns and other hot topics between panelists Senator Ernesto Scorsone, Representative Addia Wuchner, and Representative Tim Firkins. All three panelists were forthcoming about their concerns for health care and all were engaged in nursing concerns.

Kentucky Attorney General Jack Conway was the keynote speaker and he was quick to demonstrate a strong awareness of patient safety concerns and the need for stronger whistleblower protections for nurses and others. He reflected on the experiences of his sister, who is a nurse, and the brutal realities she often faced on the job of a system that was not always designed to protect the safety of patients. The Attorney General expressed his commitment to work with the KNA to advance patient safety by advocating for stronger laws to protect patients and nursing and by vigorous enforcement of those laws.

The closing speaker was the highest ranking nurses in Kentucky state government. Barbara Baker, ARNP is a Policy Advisor for the Lieutenant Governor’s Office and the Office of the Secretary for the Cabinet of Health and Human Services. She delivered a presentation that introduced the audience to Lieutenant Governor Dan Mongiardo’s E-Health initiatives. Ms. Baker provided insight into one of the most significant advancements that health care and nursing are likely to experience in the next several years. It was visionary.

The program closed with a reminder that KNA and its voice of nursing are only as strong as the nurses who participate. The passage of laws that benefit patients and nursing is only possible if nurses and nursing students get involved. It only takes a letter, an e-mail or a phone call. If you want to be included on an e-mail tree, send a note to contact@kentucky-nurses.org and tell KNA that you want to be notified of legislative alerts.
2008 Award Nominations

2008 NURSE OF THE YEAR

KNA is accepting nominations for the 2008 KNA Nurse of the Year.

Honorary recognition may be conferred upon one KNA member at any Annual Convention Awards Dinner. Recipients of the award shall have contributed uniquely to the improvement of health care in the Commonwealth of Kentucky.

Criteria for selection:
1. The individual shall have made an exemplary contribution to nursing or health care in the Commonwealth of Kentucky.
2. The KNA member recipient shall demonstrate support of the KNA purpose and functions and shall be an active participant in the Association at the state or district level.

Please submit a Bio to the Board of Directors by July 1, 2008.

CITIZEN OF THE YEAR 2008

KNA is accepting nominations for the 2008 KNA Citizen of the Year.

Honorary recognition may be conferred upon one citizen at any Annual Convention Awards Dinner. Recipients of the award shall have contributed uniquely to the improvement of health care in the Commonwealth of Kentucky.

Criteria for selection:
1. The individual shall have made an exemplary contribution to nursing or health care in the Commonwealth of Kentucky.
2. The KNA member recipient shall demonstrate support of the KNA purpose and functions and shall be an active participant in the Association at the state or district level.

Please submit a Bio to the Board of Directors by July 1, 2008.

NURSING EDUCATION & RESEARCH CABINET RESEARCH AWARDS

With the growth of nursing, there is an increased need for research to provide a scientific foundation for practice. The KNA Nursing Education Cabinet has designed an award to foster research. Please consider submitting papers for review.

Criteria
1) Submit a paper published in a referred journal by a nurse researcher.
2) The time frame for research paper must be within the last two years.
3) The focus for the research shall include any aspect of clinical practice, administration, or education.
4) The published paper shall include the following:
   a) Significance of problem
   b) Demonstration of scientific rigor
   c) Clarity of analysis and conclusions
   d) Adherence to guidelines for protection of human rights
   e) Implications for nursing

Process
1) Two copies of the published research paper and an abstract of 250 words or less must be submitted to the KNA Nursing Education & Research Cabinet. Send submission to Kathy Hall, 1400 South First Street, P.O. Box 2616, Louisville, KY 40201-2616 and postmarked no later than September 1, 2008.
2) The abstract of the research paper will be published in the Kentucky Nurse.
3) Please include the current curriculum vita.

NURSING EDUCATION CABINET RESEARCH UTILIZATION AWARD

As nursing knowledge continues to rapidly expand, it is important to recognize individuals who incorporate research findings in their practice. The KNA Nursing Education Cabinet has designed an award to foster research. Please consider submitting papers for review.

Criteria
Submit a 1 or 2 page description of the project describing:
   a. Target population (e.g. clinical group, staff, student) and setting.
   b. Team members or disciplines involved.
   c. Focus of the project.
   d. Results/recommendations.

Process
1. Two copies of a paper describing research utilization in practice and an abstract of 250 words or less must be submitted to the KNA Nursing Education & Research Cabinet. Send submission to Kathy Hall, 1400 South First Street, P.O. Box 2616, Louisville, KY 40201-2616 and postmarked no later than September 1, 2008.

NURSE RESEARCHER AWARD

1) Two copies of a paper describing research utilization in practice and an abstract of 250 words or less must be submitted to the KNA Nursing Education & Research Cabinet. Send submission to Kathy Hall, 1400 South First Street, P.O. Box 2616, Louisville, KY 40201-2616 and postmarked no later than September 1, 2008.
2) The abstract of the research paper will be published in the Kentucky Nurse.
3) Please include the current curriculum vita.

NURSING EDUCATION CABINET INNOVATIVE TEACHING AWARD

The Innovative Teaching Award is designed to recognize Nurse Educators in academic institutions and/or staff development/Continuing Education settings. Individuals nominated should have shown evidence of the creative presentation of concepts related to nursing practice, management, economics, legal and/or ethical issues, and/or research.

Criteria
The Nurse Educator:
1) Demonstrates creative teaching methodologies in an accredited nursing education program or in a Staff Development/Continuing Education program in Kentucky.
2) Presents evidence of positive outcomes on learner or recipient of program.
3) Participates as an active member of the Kentucky Nurses Association.
4) Is endorsed by two colleagues/participants.

Process
1) Nursing education program directors, staff development coordinators, CE providers, KNA members, and Kentucky Association of Nursing Students (KANS) members are urged to nominate outstanding teachers.
2) The letter of nomination should include a brief (no more than two pages) description of the creative teaching methodologies utilized by the nominee. Also, the letter should include evidence of membership and involvement in Kentucky Nurses Association activities.
3) A current resume or curriculum vitae and two letters of recommendation should accompany the nomination.
4) Nominations are to be submitted by September 1, 2008.
5) Members of the KNA Education & Research Cabinet will review the nominations and select an award winner.
6) The Chair of the Nursing Education and Research Cabinet will notify nominees of the decision of the committee.
7) A plaque will be presented to the winner of the Innovative Teaching Award at the Awards Dinner during the October 2008 KNA Convention.
Greetings! The Kentucky Nurses Association’s Education and Research Cabinet is sponsoring a poster session at the annual KNA Convention. The Cabinet cordially invites all faculty, students, and nurses in practice who have conducted research, utilized research findings in practice, and/or developed creative educational training models to share the findings and results. This is a wonderful opportunity to highlight the great things occurring in nursing in a very collegial atmosphere. This event may create the spark that ignites the flame of passion in a burgeoning future nurse researcher to find one’s niche in the profession, and gives meaning to the words “evidenced based practice” for all.

We are seeking a broad array of research and educational projects. These could include: research in progress, completed research, hospital or community based studies, teaching strategies that have been analyzed using evaluative research, graduate student research projects, and innovation in practice settings. Hospitals, clinics and outpatient settings provide the backdrop for great things to occur as well; hospitals currently deemed Magnet status or aspiring to that level of quality will want to share ideas in service to the profession and community. Poster presentations can take the form of tabletop displays or power point displays. Think about it, and be part of the Centennial Celebration!

All participants will be awarded a Certificate.

Registration fee is $50 for Thursday, October 16 of the convention, but participants must register by October 1, 2008.

The KNA Convention will be held on October 16-17, 2008 at the Marriott East in Louisville.

The Poster Session will be held on Thursday, October 16, from 4 p.m. until 6 p.m. as a continuing education (with wine and cheese) session.

*The attached Presenter’s Information form and an Abstract must be completed and returned to Kathy Hall (502) 637-2546 ext. 10 (contact@kentucky-nurses.org) no later than August 15, 2008 with attention directed to the Education and Research Cabinet, PO Box 2616, Louisville, Kentucky 40201-2616.

We look forward to seeing you at the 2008 Convention!
During the 2008 Legislative Session, the KNA prioritized the need to strengthen “whistleblower” protections so that nurses and others can safely speak up when the safety of patients is threatened by inappropriate care. For ten years the law in Kentucky has said that retaliation against whistleblowers is illegal. But law and regulation were developed to clearly outline how someone reports inappropriate care, who investigates the report, or who enforces clearly outline how someone reports inappropriate care. For ten years the law in Kentucky protections so that nurses and others can safely prioritize the need to strengthen “whistleblower” protections so that nurses and others can safely

This knowledge base for professional nursing practice includes an awareness of the law, legal and legal issues associated with practicing in the highly regulated and dynamic healthcare environment. Individual nurses have the responsibility for the nursing care provided, nursing judgments made, and actions or omissions in their own individual nursing practice. It is the declared policy of the General Assembly of Kentucky that the practice of nursing should be regulated and controlled as provided herein and by regulations of the Kentucky Board of Nursing in order to protect and safeguard the health and safety of the citizens of the Commonwealth of Kentucky. All individuals licensed or privileged under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals’ educational preparation and experience in nursing and shall practice nursing with reasonable skill and safety.

As a Kentucky licensed nurse, you are accountable for your nursing practice. This is significant because the potential for legal and ethical ramifications for you, the individual nurse, is “personal accountability.” Liability simply means legal responsibility for one’s actions or omissions. The potential for moral liability exists because of nursing accountability. This is an inherent risk of nursing practice. For example, this potential for liability for nurses can take the form of:

• a Kentucky Board of Nursing complaint and investigation for an alleged violation of KRS 314.031;
• a criminal investigation by law enforcement for a suspected violation of a federal or state criminal law;
• a lawsuit filed by a patient alleging nursing malpractice; and/or
• an employer implementing a workplace corrective action plan because identified practice deficiency resulted in a patient injury.

Do not despair; recognition of the risks is the first step. You can implement a number of strategies to

Bermuda Triangle of Nursing Practice: Application of Nursing Law, Ethics, and Professional Practice Standards in the Nursing Workplace

LaTonia Denise Wright, RN, BSN, JD

1. begin nursing continuing education sessions with this question. Whose role and responsibility is it to inform and educate nurses on the law, legalities, and legal issues associated with professional nursing practice?
2. Is this the responsibility of Nursing Professional Associations? 3. Is this the responsibility of Nursing Employers?
4. Is this the responsibility of Nursing Boards? 5. Is this the responsibility of Nursing Schools and Colleges of Nursing?
6. Is this the responsibility of individual nurses?

Nursing’s Social Policy Statement expounds upon the social contract that exists between society and the profession of nursing and delineates three types of regulation: self-regulation, professional regulation, and legal regulation of nursing practice. Self-regulation entails personal accountability for the knowledge base for professional nursing practice.

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• a lawsuit filed by a patient alleging nursing malpractice; and/or
• an employer implementing a workplace corrective action plan because identified practice deficiency resulted in a patient injury.

Do not despair; recognition of the risks is the first step. You can implement a number of strategies to mitigate these risks and stay abreast of the law, legalities, and legal process associated with professional nursing practice. However, this requires you to:

• acknowledge and accept your role as a professional nurse in protecting your license and your nursing career;
• acknowledge and accept your role as a “risk manager” for your own individual nursing practice;

After all, who knows your nursing practice better than you do anyway? This is the most surefire way to navigate the Bermuda Triangle of Nursing Practice. The Bermuda Triangle of Nursing Practice is divided into three components which in my opinion is the application of nursing law, ethics, and professional practice standards to routine and “everyday” nursing practice.

2. See Nursing’s Social Policy Statement.
4. See KRS 314.021.
5. L.D. Wright, (October 2004). Accountability and Liability. LaTonia Denise Wright, RN, BSN, JD is a licensed RN in Ohio and an attorney in private practice. Her website at http://www.centerforamericannurses.org. 7. See vi See http://legal-dictionary.thefreedictionary.com/liability. vii The information in this article is not legal advice; its provided for educational and Informational purposes only. 8. Ms. Wright received her A.S.N. degree with high honors from Miami Dade Community College cum laude in 1994 from Xavier University in Cincinnati, Ohio. She received her Juris Doctor (J.D.) degree from the University of Cincinnati College of Law in 1997.
9. Ms. Wright is a member of the American Nurses Association, Ohio Nurses Association, Center for American Nurse Attorneys. She was elected to the ANA Congress on Nursing Practice & Economics as a member of the KNA Board of Directors in 2008. She is currently serving as the Chairperson of Delegates and Center’s Membership Council. She served on the Center’s Board of Directors from 2004-2006 and was the Editor of the Center’s legal monograph, Legal Basics for Professional Nursing Practice. For additional information about Ms. Wright and her nursing and legal background, see her website at www.advocateformynurses.typepad.com.
Kentucky Nurses Association
BIOGRAPHICAL DATA AND CONSENT-TO-SERVE

I am interested in serving on/being elected to_____________________________________________________

Name___________________________________________ Credentials (RN, MSN, etc.) ___________________

Address ___________________________________________________________________________________________

City/State/Zip___________________________________________ District # __________________________

Place of Employment______________________ E-Mail _______________________________________________

Present Position Held/Title _________________________________________________________________________

Telephone: Home___________________ Work_______________________ FAX __________________________

TYPE OF POSITION HELD:

q Administrator  
q Clinical Specialist  
q Consultant  
q C. E. Planner  
q Educational  
q Administraror  
q Educator

q Head Nurse (Manager)  
q Home Health  
q Office Nurse  
q Operating Room  
q Private Duty  
q Other___________ (Specify)

Psychiatric and Mental Health  
Public Health  
Researcher  
School Nurse  
Staff Nurse  
Supervisor (Manager)

SPECIFIC AREA OF EXPERTISE (such as AIDS, cost containment, foot care—please describe briefly)

____________________________________________________________________________________________________

PROFESSIONAL EDUCATION  
Institution  Degree Obtained

____________________________________________________________________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Professional Organizational Activities—KNA Only—(List offices and committees on national, state, or district association level for last five years. Begin with most recent positions).

District __________________________________________________________________________________________

State ______________________________________________________________________________________________

National ___________________________________________________________________________________________

Would you be willing to be a candidate for another position?  YES_____NO_____

If “YES” indicate at least two other areas in which you would be willing to serve:

____________________________________________________________________________________________________

You will be contacted prior to your name being placed on the Ballot.)

PLEASE COMPLETE A CAMPAIGN STATEMENT (100 words or less). You may include your reasons for interest in this position and/or your goals, to be published in the Kentucky Nurse.

Please attach a small photo to be published in the Kentucky Nurse (Picture is optional and will not be returned).

I understand services to the KNA are not reimbursed. If elected, I agree to fulfill to the best of my ability, the duties and responsibilities of the office for which I am submitting my name.

Signed_________________________ Date _______________________

Please return to: KNA, 1400 S. First Street, P.O. Box 2616, Louisville, KY 40201-2616 by May 15, 2008 Phone: (502) 637-2546 FAX: (502) 637-8236

District #9
Highlights

We recently surveyed our members to find out what we could do to increase meeting attendance and knowledge of district activities. Based on the replies, we have re-arranged our 2008 meeting days and times: March 17th, Monday at 7 PM; May 8th, Thursday at 7 PM; July 12th, Saturday at noon; September 11th, Thursday at 7 PM; and November 14th, Friday at 7 PM.

Minutes of meetings are now mailed or emailed to all and we have sent a membership list to everyone, along with the year’s schedule. Each meeting includes a short presentation on a current nursing issue. We end meetings with “dessert,” a joke or funny story. Members volunteer to present the issue or “dessert.”

Our district includes Anderson, Boyle, Casey, Garrard, Lincoln, Marion, Mercer, Rockcastle and Washington counties. We do have members from other counties and welcome all nurses to our meetings.

Barbara E. Sonnen
Kentucky Vehicle Enforcement Officer: 
An Occupational Assessment

Western Kentucky University 
Lisa Stewart, RN 
BSN Student

Most officers in the law enforcement field are subject to a wide variety of occupational hazards. Some of them are obvious and apparent just by being in law enforcement (e.g., physical violence, traffic dangers, etc.). However, many of the hazards associated with a law enforcement officer’s daily work may not be readily acknowledged by most outside the profession. A further look at the many integral parts of an officer’s daily work is sometimes neglected due to the select few extraordinary occupational hazards that are emphasized on television programs and other media. Law enforcement officers are a basic staple of society and unfortunately, are not given the respect they are entitled to when they are enforcing the laws of the community, state, or country. Kentucky Vehicle Enforcement (KVE) officers fulfill a unique role in upholding and enforcing the laws of the Commonwealth of Kentucky.

KVE officers are certified police officers employed by the Commonwealth of Kentucky’s Justice and Public Safety Cabinet through the Department of Vehicle Enforcement. The department has eleven regions throughout Kentucky and has a departmental headquarters in Frankfort with a region of officers dedicated to each season of the year. This region includes the Post II Region which has its physical offices in Franklin on northbound Interstate 65.

Before employment, each KVE officer must undergo a thorough background investigation, a complete physical and psychological evaluation, and must pass several qualifying tests. After the KVE officer is hired, he must attend the Police Academy at Richmond which is required of all law enforcement officers if they are not previously certified. In addition to Academy, KVE officers must attend and successfully complete a wide variety of training specific to their enforcement role including, but not limited to, hazardous materials training, commercial truck inspections, drug interdiction, and an ever-evolving terrorism detection and prevention training series. Yearly qualification with all weapons a KVE officer carries at any time is mandatory. Of course, the KVE officer must be aware of all federal, state, and local laws applicable to specific area and their applications, fines, and punishments. Also, KVE officers must act as a peace officer whenever necessary, even when not dealing with commercial vehicles. Therefore, KVE officers are fully-certified police officers and have full authority throughout the state.

Physical Risks

Physical risks are an inherent part of any law enforcement job. KVE officers face physical risks regardless of where they are assigned to work during the course of their shift. If an officer is assigned to the actual post, he must maintain a safe working environment for all personnel, including unarmed inspectors, clerks, and secretaries, in addition to his regular duties. When an officer is assigned to work a specific county or counties, his physical risks increase dramatically due to the nature of working alone on public roadways, usually in heavily-traveled areas.

Physical risks encountered at the post include the danger of physical violence from the people they encounter in the course of their enforcement duties, falls due to irregular surfaces that may be coated with various engine, brake, and other petroleum substances, and muscle strain or tears, stress fractures, and other skeletal impairments due to lifting, rotation, bending, reaching, and various other ranges of motion encountered in routine inspections of commercial vehicles. With temperature extremes and their effects on both the officer’s body and the equipment he operates, each season of the year also brings a unique set of physical risks to the officer assigned to the post.

When an officer is assigned to a county or counties, commonly referred to the road, the set of physical risks encompasses all of the aforementioned risks of an officer assigned to post plus a vast array of physical risks that have a wide range of severity from mild to fatal. The most obvious of the physical risks faced by the road officer is danger from moving vehicles. These vehicles can include the vehicles he is pursuing, the cruiser he is driving, and other traffic not directly involved in the pursuit of traffic stop. A driver trying to get a closer look at what the officer is doing can often inadvertently steer toward the cruiser on the side of the road, perhaps striking the cruiser and/or the stopped vehicle and people in or nearby vehicles.

A major risk of skeletal injury for the road officers comes from pushing and placing portable scales to weigh commercial trucks. Each officer carries a set of four scales in the trunk of his cruiser. Each individual scale weighs approximately 60 pounds. These scales replaced the former portable scales that weighed 80 pounds each. The officer must lift each of these scales, carry the scales to the appropriate positions on the truck, and physically place the scales at a precise location in order for the truck to safely pull onto the scales and be accurately weighed. Yet another risk that comes from weighing a truck with portable scales is when truck drivers try to break the scales when they are pulling up on them, resulting in scales being forcefully propelled toward the officer or the truck veering toward the officer due to an imbalance.

Each season brings a unique set of risks to the road officer as well. With any inclement weather, wrecks, motorist assists, and physical risks to the officer rise dramatically. Because the officer’s required polyester-blend uniform requires full compliance at all times, extreme heat can increase the officer’s risk of heat exhaustion. If an officer is working a wreck, he may be out in extreme temperatures for hours without relief due to the limited number of officers assigned per region due to state budget constraints. In addition, the officer’s obligation to protect the public doesn’t cease when weather conditions deteriorate. Pursuits and apprehensions of criminals endangering the lives of others become proportionally more dangerous during inclement weather.

The weight of the upper portion of an officer’s uniform including his bullet-proof vest, gun belt, and equipment can exceed 36 pounds. This additional constant weight can cause unexpected strain on load-bearing joints and can make the officer more susceptible to falls due to the unequal distribution of perceived body weight. The ergonomic aspects of the KVE officer’s occupational risks will be addressed in a separate section.

Unfortunately, physical risks may be encountered by the KVE officer who has enforced the law. When a large load of illegal drugs or drug money is confiscated or when criminals are apprehended, many people associated with these events blame the arresting officer. Even though the perpetrators were the ones who committed illegal acts, the focus of their violence and threats becomes the arresting officer. These circumstances can also produce enormous psychological risks to the arresting officer, especially those officers who have their families also threatened.

(continued on page 9)
Chemical Risks

The actual job description of a KVE officer addresses the potential of the officer on a regular basis to be exposed to some chemical risks. The officer may not always be aware of what chemical he is dealing with as there are a large number of exemptions to the placarding of commercial vehicles carrying chemicals. On a daily basis, KVE officers can potentially be exposed to chemicals and poisons of all types including inhalants, corrosives, 1.1 to 1.4 explosives, flammables, combustibles, oxidizers, medical waste containing chemicals, radioactive substances—literally anything and everything that needs to be transported from one location to another. The chemical risks the officer is exposed to can come from chemicals used to maintain equipment and vehicles integral to his work as well. An officer can be exposed to these chemical risks through a variety of routes such as skin or eye contact from splashes, drips, or spills, inhalants, accidental injection with a sharp or inadvertent ingestion.

Ergonomic Risks

According to the KVE officer, his biggest biological risk is presented by medical waste. Most of these biohazards do not require placarding, and many drivers are completely unaware of what they are actually carrying on the interstate. The drivers have just hooked to trailers that have already been loaded and given nondescript bills of laden. An officer can be exposed to any biohazard imaginable without any way to exactly track the source of the substance he was exposed to in the event of a spill, splash, or stick.

In addition to legal substances, the trafficking of illegal drugs across state lines is encountered daily by KVE officers. Within the past few months, the largest drug seizures in Kentucky have been made by KVE officers during routine searches.

Psychological Risks

The KVE officer, as well as all law enforcement officers, is exposed to extreme psychological risks. According to the former post chaplain, “...law enforcement officers have one of the highest risks of suicide of any profession.” A KVE officer may put a commercial vehicle out-of-service for a safety violation causing the driver to lose his job if he is employed by the trucking company or may cause the driver-owner to lose not only that shipment’s payment, but also the possibility of any future business from that manufacturer or supplier. Because of the process of the action of putting a commercial vehicle out-of-service, the cited driver may verbally place blame on the officer who was protecting the public.

Technology Risks

An unusual technological risk exclusive to Post II involves the detection of radioactive substances. A Homeland Security Grant provided Post II with a road scanner that scans the commercial vehicle’s cargo for any radioactive substance as they pass the lane by the scales. These scanners can alert on any substance that might give off a radioactive signal including contrast dyes, kitty litter, and true radioactive substances. When an alert is received, the commercial vehicle, usually a tractor-trailer, is parked. At that time, a major technological risk presents. To affirm the alert and rule out false alarms, an officer must use a handheld scanning device to determine the presence of a true radioactive hazard. At this time, there are no safeguards in place if an officer comes in contact with a non-contained radioactive substance when using the handheld scanner.

Nursing Diagnoses

The inherent risks associated with the KVE officer’s daily tasks can find applications in numerous nursing diagnoses. However, Risk of injury related to occupational hazards (pick any of the aforementioned items) must be the most applicable nursing diagnosis. Another perhaps less apparent nursing diagnosis for any law enforcement officer is Spiritual Distress related to conflicting personal emotions as evidenced by feeling responsible for the personal hardship to the arrested individual and his family, feelings of not having done enough for the victims of a wreck, and/or feelings of not keeping his family safe from threats of violence by arrested criminals.

In conclusion, the job of a KVE officer is mentally, emotionally, and physically demanding. Not all of the occupational risks that KVE officers are exposed to on a daily basis are contained within this paper. The Justice and Public Safety Cabinet has a responsibility to its employees to continue to lessen or eradicate the exposure to occupational risks encountered on a daily basis by members of the Department of Vehicle Enforcement. Through awareness efforts by the different regional posts throughout the state, the Cabinet can begin to address these occupational hazards in a timely and effective manner and try to minimize or eliminate all projected occupational risks to the KVE officers.
Managing Cholesterol

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Introduction
Hypercholesterolemia affects over 100 million Americans and is one of the major risk factors for cardiovascular disease and stroke. This condition may be preventable and is treatable with the implementation of lifestyle changes and medications that have been shown to be effective in reducing risk factors. The intent of this literature review is to increase awareness of the latest guidelines by the National Cholesterol Education Program Adult Treatment Panel III for optimal lipid levels, and to provide education about the therapeutic changes necessary for cholesterol management. This intent is in keeping with the Healthy People 2010 goals which include: reducing mean total blood cholesterol levels among adults to 190mg/dl, reducing the proportion of adults with high total blood cholesterol levels for increasing the proportion of adults who have had their blood cholesterol checked within the preceding five years to 80 percent, and increasing the proportion of persons with coronary heart disease who have their LDL cholesterol level treated to a goal of less than or equal to 100mg/dl (U.S. Department of Health & Human Services, 2000).

Literature Review
Each year more than a million Americans suffer a myocardial infarction (National Institute of Health, 2004), with an average of one death every 34 seconds (Engler, 2004). Cardiovascular disease remains the leading cause of death for both men and women in the United States, accounting for 39.4% of all deaths in the year 2000 (Aronow, 2003). Hypercholesterolemia remains one of the major risk factors for heart disease and stroke, with an estimated 105.2 million American adults exhibiting a total cholesterol level of 200mg/dl and higher. Approximately 36.6 million American adults have total cholesterol levels of 240 or above, which is considered in the high risk category (American Heart Association, 2007a). Clinical trials support therapeutic lifestyle changes as an essential component in clinical management. The Adult Treatment Panel III (ATP III) of the National Cholesterol Education Program has issued evidence based guidelines for more aggressive use of LDL-lowering drugs, especially for those in high-risk categories (Grundy, et al., 2004).

Current recommendations are for everyone age twenty and older to have a lipid profile done at least once every five years. Those with known diabetes and cardiovascular disease should have their levels checked on a yearly basis. Every three month testing may be necessary to track the effectiveness of lifestyle modifications and/or the effectiveness of lipid lowering medications. Optimal blood cholesterol levels or total cholesterol levels should be less than 200mg/dl, LDL to be less than 100mg/dl, HDL to be 60 or higher, and triglycerides to be less than 150mg/dl (National Institute of Health, 2004).

A 2004 update to the National Cholesterol Education Program’s (NCEP) clinical practice guidelines advises that primary prevention of cardiovascular disease is aggressive treatment plan for patients who are at higher risk for heart attack. For those at very high risk, those who have cardiovascular disease with other multiple risk factors, the new therapeutic goal is aggressive treatment until LDL is under 70mg/dl. It is now recommended that high risk patients with an LDL 100-129mg/dl be prescribed cholesterol lowering medications, with a goal of 30-40 percent reduction in LDL levels. All patients at high risk are candidates for therapeutic lifestyle changes (TLC) regardless of their LDL level (Grundy, et al., 2004).

The three main components of therapeutic lifestyle changes (TLC), that have proven effective in improving cholesterol levels include dietary changes, maintaining proper weight and weight loss if needed, and regular physical exercise. A diet low in saturated fat and cholesterol is recommended. Total daily caloric intake should not exceed 30 percent fat, with no more than 7 percent of calories from saturated fat, found mostly in animal products. Cholesterol intake should be limited to less than 300 mg of cholesterol per day. This can be achieved by choosing lean cuts of meat and increasing consumption of vegetable alternatives such as beans and soy products, selecting fat free and low fat dairy products, and limiting intake of pastries and fast food. The 2002 obesity prevention guidelines recommended that Americans consuming 2100 calories should reduce their intake of trans fatty acids. It is recommended that non-hydrogenated margarine, in either liquid or tub form, be used instead of butter. The best choice is one with zero trans fat and no more than two grams of saturated fat per tablespoon with the main ingredient liquid vegetable oil (Tsang, 2006). Trans fatty acids have a similar effect as saturated fats in raising LDL and lowering HDL and should be avoided. They are found in a variety of foods, especially commercially packaged products such as cookies and crackers. Trans fatty acids are formed during the processing of vegetable oils and can be recognized on labels as “partially hydrogenated oil” (Collins & O’Neill, 2004). The FDA ruled that starting January 2006, all products had to be labeled with the trans fat content. The consumer needs to be aware that a product could be labeled as zero trans fat per serving yet still contain some trans fat if “partially hydrogenated oil” is listed in the ingredients. Research suggests that plant stanol and sterols found in cholesterol-lowering margarines and salad dressings can help decrease LDL by 9-14 percent with doses of two or more grams per day. Stands and sterols are considered to be safe but can decrease carotene levels. Those can be easily remedied with an additional serving of a high carotene food. Further research is needed to investigate adverse effects of long term use of plant stanols and sterols (Gonella, 2003).

Regular physical activity of thirty minutes on most days is recommended, with intensity and duration increasing slowly as guided by a health care provider. Exercise has been shown to increase HDL and lower LDL and triglycerides (National Institute of Health, 2007). For some, especially those with a genetic predisposition to hypercholesterolemia, therapeutic lifestyle changes may not be enough to bring lipid levels under control, and medications are often necessary. There are a variety of drugs available, including statins, bile-acid binding resins, cholesterol absorption inhibitors, fibrates, and niacin. The revised guidelines of the NCEP recommend the initiation of cholesterol lowering medications when LDL is 190mg/dl or higher in patients with certain risk factors. When LDL is 160mg/dl or higher with two or more risk factors and less than a 10 percent risk of having heart attack in the next 10 years, or when LDL is 130mg/dl or higher with two or more risk factors and a 10 percent risk of having a heart attack in the next 10 years (Mayo Clinic Medical Services, 2004).

Recent national organizations endeavors to promote cholesterol lowering awareness, including the Center for Disease Control, the American Heart Association, the National Institutes of Health, the National Heart, Lung, and Blood Institute, and the American Diabetes Association. All of these organizations have easily accessible resources that may be valuable. Many publish electronic newsletters that are free of charge and sent upon request. They frequently contain articles on cholesterol lowering management and healthy lifestyle changes. Two of the most helpful newsletters providing consumer education are from http://www.mayovlinic.com and http://americanheart.org.

In 1998, the U.S. Congress provided funds for the initiation of state based heart disease and stroke prevention programs, which includes funding for decreasing the risk factors for high cholesterol. Currently, 53 states and the District of Columbia are funded as cardiac state coalitions to conduct basic implementation programs. Kentucky is in the “capacity building” status, which means the CDC collaborates closely with the state health agencies and sectors and assesses population based strategies for heart disease and stroke prevention. The CDC offers a national database and a series of resources for prevention that are culturally appropriate and that strive to eliminate disparities (Center for Disease Control, 2007).

On the local level throughout the state, there are a variety of resources for the consumer to receive cholesterol screening and education. Most local hospitals provide cholesterol screening services through the means of health fairs and seminars. Many local pharmacies, fitness centers and department stores offer special sessions for cholesterol screenings. Frequently, churches sponsor cholesterol screening as part of a yearly health fair. County health departments have chronic disease prevention departments where health education is provided free of charge. Opportunities abound for the healthcare consumer to become educated and proactive. The time is now to get healthy.

References
Recruitment and Retention of Nurse Educators: An Imperative Intervention to Decrease the Nursing Shortage

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The United States faces a critical shortage of full time registered nurses as the Health Resources and Service Administration (HRSA, 2004) estimates that one million vacancies will occur by the year 2020. This shortage of practicing registered nurses is directly affected by the shortage of nurse educators. The current vacancy rate of nurse educators is 8.4%, with an average of 2.2 vacancies reported per school of nursing. A recent survey by the American Association of Colleges of Nursing (AACN, 2007) found that 71.3% of nursing schools reported vacancies and were in need of additional faculty. The all time high vacancy rates can be attributed to several factors, including insufficient funds for full time positions, competition with organizations that pay more, age of faculty, lack of younger faculty entering the field, and job dissatisfaction (AACN, 2007). Two major areas of focus in preventing nurse educator vacancies are retention of nurse educators, including those nearing retirement, and recruitment of younger nurses to fill the vacant educator positions.

Factors affecting the Nurse Educator Shortage

Nurse educator retirements are expected to increase over the next several years. The average age of retirement for nurse educators is 62.5 years, and a majority of nurse educators are between 46 to 65 years of age and plan to retire in the next 15 years (Berlin & Sechrist, 2002; Kowalski, Dalley, & Weigand, 2006). National League for Nursing (NLN, 2006). Many schools of nursing are already seeing the impact of nurse educator shortages, as qualified program applicants are being turned away due to lack of qualified educators available to teach them (AACN, 2005; Berlin, Stennet, & Bednash, 2003). The retirement of nurse educators will cause an increase in vacancy rates and a decrease in the number of students accepted in nursing schools, thus the number of nurses being produced. Not only is the increasing rate of retirement for nurse educators affecting the shortage, but the hesitancy of qualified, younger nurses to fill vacant positions is furthering the problem. In recent years, there has been a decline in doctorally prepared nurse educators in the younger age groups: 0.6% are < 35 years of age, 19.4% are 36-45 years of age, and 2.1% are 46-55 years of age (AACN, 2007). There has also been a similar pattern of decline in master’s prepared nurse educators (AACN, 2007). Issues which have discouraged nurse educators from entering the field of teaching and furthering academic studies include the requirement to maintain competency in their area of clinical expertise and in the areas of teaching, service, and scholarly activities (Evans, 2005).

Studies show that job satisfaction plays a major role in the decision of nursing faculty to retire and for new nurse educators to not enter academia. Factors that can negatively impact satisfaction include multiple demands placed on faculty in the areas of teaching, scholarship, and service (AACN, 2005; Budden, 1994; Lewallen, Crane, Letvak, Jones, & Hu, 2003). The stress of succeeding in these areas can prompt those eligible for retirement to retire at an earlier age and discourage prospective educators from entering the academic setting. Although teaching remains the primary role of the nurse educator, nurse educators are often required by their institutions of higher learning to participate in service activities and projects, such as committee work and community service. Many institutions also require faculty to participate in research production or scholarly presentations in order to obtain tenure and promotion (Fairweather, 1993, 2005; Migone, 2000).

High faculty workload has been cited as a critical issue faced by schools of nursing (AACN, 2005; Kowalski, Dalley, & Weigand, 2006). Studies have shown that educators work as many as 56 hours per week in their roles as educators (NLN-Carnegie Study; as cited in Kaufman, 2007 a & b) and then must work additional hours in the area of clinical practice. Educators who held certifications in specialty areas and those who serve as nurse practitioners (NPs) or clinical nurse specialists (CNSS) are required to work in their specialty areas in order to maintain certifications. For example, certification through the American Nurses Credentialing Center (ANCC) requires a minimum of 1000 practice hours within the five year renewal period in additional to extensive continuing education requirements. (ANCC 2007).

Another major factor affecting the nurse educator shortage is compensation. Salaries of nurse educators are relatively low compared to master’s and doctorally prepared counterparts working in settings such as hospitals and private practices. Nurse educators cite lack of competitive salaries in academic settings as a serious concern (Kaufman, 2007a). In fact, the median income for a master’s prepared assistant professor is $858,567 and a doctoral prepared assistant professor earns $868,444 annually. Those working out of the academic setting earn significantly more annually; Nurse Anesthetists earn $121,698, Nurse Practitioners earn $68,444 annually. Those working out of the academic setting and furthering academic studies (Kaufman, 2007a & b).

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Recruitment and Retention

A major focus of schools of nursing should be recruitment and retention of nurse educators. Healthcare facilities employing nurses have been (continued on page 12)
recruiting nurses for years and have aimed to retain nurses to decrease costs and improve client care. Academic institutions can gain financially by recruiting and retaining nurse educators and ensuring a high quality product, education, is provided to students. In order to ensure adequate numbers of nursing graduates, the number of retiring nurses must be decreased by implementing measures to improve job satisfaction and flexibility for those nearing retirement. Additionally, programs and processes that allow new nurse educators to meet the many expectations placed upon them in a positive and non-stressful manner are imperative. New nurse educators are in need of mentoring, flexibility of assignments, and departmental and university wide support and camaraderie (Brown, 1999; Soricelli, 2002). Flexibility in meeting the requirements in the areas of teaching, service, and scholarship should be provided as a means to recruit and retain. For example, a nurse educator interested in primarily research activities should be allowed to make this a majority of his or her workload. Other educators in the department may prefer teaching or service to be the majority of their workloads. Distribution of these activities among educators can be made so faculty can decide how to spend their time and still meet the needs of the school of nursing. Additionally, schools of nursing could explore the concept proposed by Boyer (1990) who cited the importance of recognizing practice and teaching as scholarly work, in addition to research activities. New nurse educators need to feel included in institutional and departmental culture. Often, new educators report a feeling of exclusion and experience a high level of dissatisfaction in the lack of support in their transition into the new role (Brown, 1999; Soricelli, 2002). Moreover, nurse educators report incivility from nursing students and lack of support from colleagues, which has a negative impact on their view towards their role (Baker, 2007; Clark & Springer, 2007). Positive mentoring relationships can have a profound impact on new educators by providing support when they are faced with these challenges. Mentoring also benefits experienced nurse educators by empowering them to feel they are impacting future generations of nurse educators (NLN, 2006). Effective mentoring can decrease job dissatisfaction of new and experienced nurse educators.

Johnson & Johnson (2007) recently launched a campaign to recruit nurse educators, recognizing the need to address this shortage in their effort to produce enough nurses. Recruitment activities are imperative for academic institutions as they struggle to meet the growing demand to produce more nurses. Often, vacant positions are posted on the internet and in national or in magazines and spread by word of mouth. Schools of nursing must be more proactive in developing up and coming educators. For example, nurse educators should identify potential educators as they interact with staff nurses and managers during clinical experiences. Often, these nurses may be interested in teaching, but may be misinformed about qualifications, educational requirements, or expectations. These potential educators can beancaught to join the academic setting and provided guidance with their education and professional development.

Maintaining good rapport and a professional image by nurse educators, are excellent qualities to recruit nurse educators (AACN, 2005). Being positive in all interactions with staff nurses, management, students, and colleagues can help recruitment efforts. Negativism about nursing and the teaching role can have a negative impact on the desire to enter the academic setting. Nurse educators must highlight the positive aspects of their positions and the positive impact they have on student success and client care. Telling others, “I love what I do for my students, clients, and colleagues,” can have a huge impact on how others view the nurse educator role. Looking at current part time educators as potential full time educators is crucial. Many of those part time educators working in the clinical setting would be excellent full time educators, given the mentoring and tools they needed. These part timers are often not prepared to take on a role as full time faculty, with all of the responsibilities and pressure the role requires, but may be interested in doing so in the future. Part time faculty may enjoy their role as clinical instructors or guest lecturers as they pursue additional education, care for their children, or practice as a specialist in a specific area. All educators in our schools of nursing must encourage and mentor part time faculty and prepare them for future full time responsibilities. 

Academic settings must also evaluate salaries for nurse educators to make them more comparable to other masters and doctorally prepared nurses working outside of academia and to colleagues in other academic departments. Not only are nurse educator salaries lower than their nurse counterparts, but they are significantly lower than faculty in other disciplines (NLN-Carnegie Study: as cited in Kaufman, 2007a). This salary disparity has an even greater impact on the decision of qualified nurses to enter academic settings. Some schools of nursing are providing nurse educator stipends, available through grants and various other funds, to help alleviate the salary disparity (Trigg, 2007). Nurse educator salaries must increase in order to prevent retirement and aid in recruitment.

Conclusion

Nursing schools must evaluate the needs of their nursing educators to implement plans for recruitment and retention. Implementing job satisfaction through mentoring and flexibility are important recruitment and retention strategies. Nurse educators should be encouraged to display a positive attitude about their roles in the community and healthcare settings and to establish constructive relationships with colleagues inside and out of the academic setting. Providing for supportive, collegial relationships should be increased. Salary activities and can also assist in decreasing the vacancy rates of nurse educators. Although barriers exist, it is important that academic institutions overcome these challenges in order to ensure an adequate supply of future nurses will exist.

References


References
A nursing shortage is present in the United States and is expected to get worse (American Association of Colleges of Nursing [AACN], 2007). A major contributing factor to the nursing shortage is the concurrent scarcity of nursing faculty. In 2006, over 40,000 qualified applicants to nursing schools were unable to be accepted due in part to the insufficient number of nurse faculty [AACN]. The shortage of nursing faculty is related to numerous factors; one being the average age of current nurse educators in academia. According to Kaufman (2007) “48 percent of nurse educators are 55 and older” (p. 65). In addition, approximately, one-half of current nursing faculty report plans to retire within the next decade (Kaufman). Therefore, it is imperative that successive planning be implemented to recruit the next generation of nurse educators.

However, there are barriers to succession planning in nursing education. Faculty in baccalaureate nursing programs recognize that nursing students often do not consider the nurse educator role as a career path and expert educators point out that attracting students to nursing education concentrations in master's programs is difficult. The lack of interest and desire to pursue the educator role stems from many issues including salary, workload, and misunderstanding of multiple faculty roles (Kaufman, 2007). Therefore, current nursing faculty members have the opportunity and responsibility to promote nursing education as a viable and rewarding career option for students.

The School of Nursing at Western Kentucky University (WKU) has experienced the shortage of educators first hand. In order to meet the needs of constituents for more nurses, the number of students admitted has increased dramatically while positions vacated by retiring faculty are difficult to fill at times. Additionally, novice faculty may leave nursing education due to being unfamiliar with the multiple roles faculty are required to fulfill. To increase the potential applicant pool for nursing education positions, awareness of the role and expectations of the nurse educator must begin in undergraduate education. Boyer (1990) noted the faculty role included much more than the scholarship of teaching. This remains evident in tenure and promotion guidelines in most college/ university settings. The requirements include research and publication, teaching, service, and maintaining current knowledge in area of practice (Boyer).

The nursing faculty at WKU recognize the value of role-modeling as a technique to encourage students to consider nursing education as an area of advanced practice. As students progress through a nursing program, they begin the process of professional socialization through their many educational experiences, which allows for observation of faculty in multiple roles. In the BSN prelicensure program, they begin the process of professional socialization through their many educational experiences, which allows for observation of faculty in multiple roles. In the BSN prelicensure program at WKU, professional socialization occurs not only formally during traditional classroom and clinical activities, but also informally. Informal socialization occurs through participation in a variety of activities. These include maintaining active membership in the pre professional organization (e.g., Kentucky Association of Nursing Students), participating with faculty in community service events, attending continuing education offerings focusing on current issues, assisting faculty with research, and in teaching others in the community about health related issues. These activities offer students opportunities to observe faculty in the roles of service, teaching, practice, and research. Role-modeling the importance of each faculty role helps students to see that faculty members have diverse responsibilities, of which classroom teaching is just one. These formal and informal interactions with faculty allow students to see the diversity and complexity of faculty life. Hopefully, by observing faculty members in these roles, students will think about pursuing nursing education as an exciting professional career choice. As stewards of the practice of nursing, we must assume the responsibility of not only teaching the next generation of nurses, but helping plan for the next generation of nurse educators. Promoting the advanced practice of nursing education safeguards the future of our profession.

References
The exact weight of a child undergoing resuscitation in a pediatric emergency department is critical to implementing protocols to save the child's life. These weight dependent protocols involve titrating drug dosages to the child's body weight in order to maximize the effect of the therapy while minimizing the toxic effect of the drug. Commonly, estimating circumstances preclude the assessment of the child's weight by using a standard scale. These circumstances include the conscious and cooperation of the child, severity of illness or injury, stability of the child's condition, as well as temporary braces to stabilize the child's back, neck and/or extremities. The purpose of this study was to compare the accuracy of five methods of estimating a pediatric patient's body weight in the pediatric emergency department (ED). The five methods compared included a physician's estimate, a nurse's estimate, the patient's parent's estimate, the estimate compared to their height (Lobstein and Jackson-Leach, 2007). Thus, the physician's, nurse's and parent's estimate of the child's weight may need to be considered in the final estimate of the child's weight which is employed in their pediatric ED experience, and physicians had an average of 6.5 years. The estimates of the nurses and physicians at this pediatric hospital were highly accurate, but it is not known if practitioner estimates would be more accurate than the Broselow or DWEM methods across multiple settings. The accuracy of parent estimates in this study could be due to the population of children studied being recently seen by their pediatrician, and weighed in the office, then sent to the ED for additional care or evaluation. Based on these limitations of the study, it is not recommended that physician, nurse or parent estimate preclude the use of an objective methodology. Of the five methods compared, the Broselow and DWEM methods were the least accurate in estimating the child's weight. This finding is contrary to recommendations in the literature which indicate that the Broselow and DWEM are the most accurate methods of weight estimation in children (Black, Barnett, Wolfe and Young, 2002). This finding may be due to the Broselow and DWEM methods being based upon standard height and weight tables which were developed by Metropolitan Life in 1943 and since that time children have gained in body weight relative to their height (Lobstein and Jackson-Leach, 2007). Thus, the physicians', nurse's and parent's estimate of the child's weight may need to be considered in the final estimate of the child's weight which is employed in their care.

### Table 1. Correlation between actual and estimated weights

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KNA PRODUCTS
Order Form

KNA Golf Shirt—Short Sleeve—
Available in Red or Royal Blue—$25.00 or $27.00 (2X and 3X Large Size) each
plus shipping & handling and tax:

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KNA Microfleece Vest—Available
in Red or Royal Blue—$32.00 or $34.00 (2X Large Size) each
plus shipping & handling and tax:

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KNA Post-It-Note Cube $6.00
KNA Mini-Umbrella $12.00
KNA Red, White & Blue Centennial Canvas Bag $15.00
Red and Blue Vinyl Flag Tote Bag with white KNA Luggage Tag $10.00
Black KNA Travel Bag $10.00

*These sizes are an additional $2.00 each

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<td>KNA Red, White &amp; Blue Centennial Canvas Bag</td>
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FACULTY

Suzanne Hall Johnson, MN, KNC, CNS is the Director of Hall Johnson Consulting and the Editor of Nurse Author & Editor. She is a Clinical Nurse Specialist, UCLA graduate with honors, and a Distinguished Alumni from Duke University. (Copyright 2003 Suzanne Hall Johnson)

To order, please check the box in front of the Home Study or Audiotape Course(s) you want to purchase, complete the information below, and return with your check, money order or credit card information to:

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Professional Nursing in Kentucky
Yesterday Today Tomorrow

The historical narrative, *Professional Nursing in Kentucky: Yesterday, Today, Tomorrow*, is a KNA Centennial Project. Research and authorship was a collective effort of the KNA Centennial Publication Committee. The content was derived from published and unpublished documents in public and private archives of Kentucky schools of nursing, hospitals, colleges, universities, health agencies, libraries and historical societies. Selected photos and individual anecdotes lend a personal touch.

Proceeds from the sale of this book will benefit the Kentucky Nurses Foundation in forwarding its mission of providing nursing scholarships and funding nursing research.

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“NURSING: LIGHT OF HOPE”
by Scott Gilbertson
Folio Studio, Louisville, Kentucky

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

NOTE CARDS (package)—5 for $6.50

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Phone: (502) 637-2546     Fax: (502) 637-8236
The Human Touch

Copyright 1980
Limited Edition Prints
by
Marjorie Glaser Bindner
RN Artist
Limited Edition Full Color Print
Overall size 14 x 18

Signed Only (1250)—$20.00
Note Cards (package)—5 for $6.50
Framed Signed—$160.00
Cherry or Gold Frame

THE PAINTING

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

THE HUMAN TOUCH

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

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

RN Poet
Beckie Stewart*

*I wrote this poem to describe the painting, The Human Touch by Marge.

FOR MAIL ORDERS

I would like to order an art print of "The Human Touch"

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_________ Framed Signed Print @ $160.00

Gold Frame
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$45.01 to $60.00 ....................................... $10.50
$60.01 to $75.00 ........................................ $12.00
$75.01 to $90.00 ....................................... $19.00
$90.01 to $150.00 ...................................... $25.00
$151.01 to $200.00 ................................. $35.00
$201.01 to $300.00 ................................. $50.00
$300.00 and up ................................. $65.00

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Medication errors are a major cause of injury and mortality in United States hospitals. It is estimated that hospital medication errors cause almost 100,000 American deaths each year (as cited in Fagin, 2001). Medication errors are preventable events that not only lead to injury and death of patients but also cost hospitals several billions dollars annually in expenses associated with additional treatment for the patients harmed by those errors. Most medication errors take place during medication administration by nurses so nurses are the last line of defense in preventing medication errors. Most medication error research has been conducted in large medical centers or urban hospitals. Thus, research is needed to fill the gap in the current literature regarding settings. A team from the University of Illinois at Chicago conducted a study to examine the occurrence of medication errors in a rural hospital setting. The study was conducted in a rural mid-western hospital with 100 beds, located in a community of 32,913. Data were gathered from 120 medication error reports collected over a 12-month period, using a researcher-designed Medication Error Audit Form (MEAF). The researchers established the content validity of the MEAF and calculated the instrument’s inter-rater reliability at r = .97. The investigators determined that the majority of medication errors occurring at this facility involved a medication omission or a wrong dose given intravenously. The severity of medication errors were rated on a scale from 1 to 9, with 9 being the most serious. No level 9 errors occurred during the 12-months of the study. Most medication errors were rated as a 3 on the scale, which indicated that the medication reached the patient but caused no bodily harm. The data indicated that a greater number of errors occurred on a Friday in January in the general medical-surgical unit during second shift. This mid-western hospital experienced high Friday absenteeism so patient errors could be attributed to availability of staff nurses. The hospital experienced a high percentage of admissions in January compared to other months. This could be attributed to a higher incidence of respiratory problems in winter months. The in-patient admissions for January led to a higher patient to nurse ratio. In the medical-surgical unit, nurses administered a higher volume of medications to a larger number of patients compared to other units in the hospital leading to a greater opportunity for errors. A hospital’s second shift typically has surgical patients returning to the units, transfer of patients from other units, more direct admissions, and visitation by family and friends so errors on second shift could be attributed to inadequate staffing levels, and fatigue. This rural hospital also had a lack of availability of pharmacy staff during evening and weekend shifts. The pharmacy closed at 9:00 pm during the week and 5:30 pm on weekends, so the second shift nursing staff did not have the opportunity to utilize the safeguards that the pharmacy department would have provided. The nursing staff dispensed medications directly from a Pyxis after receiving a verbal physician order.

One of the study’s primary conclusions was that medication errors were related to lower nursing staffing levels, whether due to RN absenteeism, high patient volumes, or the percentage of acute patients. The findings suggest some of the areas in which hospitals should direct their focus in order to reduce medication errors, which continue to be a significant problem in health care today.


Submitted By: Dawn Ginter and Robert Holland. BSN Students at Bellarmine University Lansing School of Nursing and Health Sciences, Louisville, KY, and LaShannda Harris, a former student.

Data Bits is a regular feature of Kentucky Nurse. Sherrill 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.

We all know safe staffing is one of the most pressing issues currently facing the nursing profession. Nurses understand all too well that inadequate staffing poses serious threats to patient safety and quality care. And nurses know that staffing issues are becoming more serious in light of today’s nursing shortage and health care crisis. We need nurses’ stories and their input and participation. Together, we can make better staffing a reality.

Combination of nurse staffing plans and legislated nurse to patient ratio: Enhancing these approaches can include a provision for making staffing information available to the public. ANA’s proposal is not a “one size fits all” approach to staffing. Instead, it tailors nurse staffing to the specific needs of each unit, based on factors including patient acuity, the experience of the nursing staff, the skill mix of the staff, available technology, and the support services available to the nurses. Most importantly, this approach treats nurses as professionals and empowers them at last to have a decision-making role in the care they provide.

Recent studies have demonstrated what most health care consumers already know: nursing care and quality patient care are inextricably linked. Massive reductions in nursing budgets, combined with the challenges presented by a growing nursing shortage have resulted in fewer nurses working longer hours and caring for sicker patients. This situation compromises care and contributes to the nursing shortage by creating an environment that drives nurses from the bedside.

We need nurses’ stories and their input and participation. Together, we can make better staffing a reality.

ANA Announces A New Website To Promote Its Staffing Campaign Safe Staffing Saves Lives

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We need nurses’ stories and their input and participation. Together, we can make better staffing a reality.

Visit www.safestaffingsaveslives.org for more information and to see how you can get involved.

(Information for this announcement is a combination of text from an ANA e-mail announcement and the www.safestaffingsaveslives.org website)
Promoting Worker and Business Health

by Barbara Hawkins, MSN, RN, C, CDMS

Most people spend the majority of their waking hours at work. That’s why it makes sense for employers to include individual and organizational health as important considerations in the workplace environment. Many employers turn to occupational health nursing specialists to provide the expert guidance needed to promote health and assist in meeting organizational goals.

Occupational and environmental health nursing is the specialty practice that provides for and delivers health and safety programs and services to workers, worker populations and community groups. The practice focuses on promotion and restoration of health, prevention of illness and injury and protection from work related and environmental hazards.

History

The first record of occupational and environmental health nursing in the United States dates back to 1888 when a nurse named Betty Moulder cared for Pennsylvania coal miners and their families. The profession evolved with the growth of industry around the beginning of the 20th century, as factories employed nurses to combat the spread of infectious diseases like tuberculosis, to address health-related problems resulting from labor shortages during World War I, and to cut costs rising health-related problems resulting from labor shortages during World War I, and to cut costs rising from new workers’ compensation legislation. Today, the scope of practice includes disease management, environmental health, emergency preparedness and disaster planning in response to natural, technological and human hazards to work and community environments. In Kentucky, occupational health nurses provide services in health care systems, insurance and benefits administration, manufacturing, utility, transportation, and major construction industries, as well as providing independent consulting practices.

Role of Occupational Health Nurses Today

The historical stereotype of the “industrial nurse”, who sat in an office and didn’t appear to do much except distribute aspirin is a myth in today’s global economy. Modern occupational health nurses (OHNs) roles are as diverse as clinician to educator, case manager to corporate director and consultant. The OHN’s responsibilities have expanded immensely to encompass not only the responsibilities previously listed but also a wide range of job duties, including but not limited to:

- **Case management:** In addition to providing treatment, follow-up and referrals and emergency care for job related injuries and illnesses, OHNs act as gatekeepers for health services, rehabilitation, return-to-work and case management issues, and are key to employers’ health care quality and cost containment strategies.
- **Counseling and crisis intervention:** Besides counseling workers about work related illness and injuries, OHNs often counsel for issues such as substance abuse and emotional and/or family problems. They also handle referrals to employee assistance programs and/or other community resources and coordinate follow-up care.
- **Health promotion:** OHNs teach skills and develop health education programs that encourage workers to take responsibility for their own health. Smoking cessation, flu shots, exercise/fitness, nutrition and weight control, stress management, control of chronic illnesses and effective use of medical services are just a few of the preventive strategies to keep workers healthy and productive.
- **Legal and regulatory compliance:** Whether it is the array of regulations put forward by the Occupational Safety and Health Administration (OSHA), Department of Transportation Commercial Driver Safety or Federal Aviation Administration requirements, drug and alcohol testing programs, or laws that affect the workplace such as the Family Medical Leave Act (FMLA) or Health Information Portability and Accountability Act (HIPAA), OHNs work with employers on compliance with regulations and laws affecting the workplace.
- **Worker and workplace hazard detection:** OHNs monitor the health status of worker populations by conducting research on the effects of workplace exposures. They gather health and hazard data, and using the data to prevent injury and illness. Examples include an analysis of the effects of toxic chemical exposures and development of plans to prevent work-related accidents.
- **Business Leadership Role:** Poor employee health costs business about $1 trillion annually, so business executives look to OHNs to maximize employee productivity and reduce costs through lowered disability claims, fewer on-the-job injuries and improved absentee rates. Through their recognized value as business partners, OHNs are both managers (implement occupational health service programs, provide budgetary input for programs and staffing) and leaders (develop policy/procedures in alignment with corporate vision/mission, supervise and direct employees, and mentor co-workers) in the effort to impact corporate improvement and employee health and safety, thus contributing positively to the financial bottom line.

Education Requirements

OHNs are registered nurses (RNs) licensed to practice in the states in which they are employed. Typically, nurses entering the field have a baccalaureate degree in nursing and experience in community health, ambulatory care, critical care or emergency nursing.

Certification in occupational and environmental health nursing is highly recommended. Criteria for certification requires 4,000 hours of work experience in the field within a five-year period, 50 contact hours of continuing nursing education in the specialty and successful completion of a national examination that requires mastery of a broad body of knowledge.

LKAOHN and AAOHN

The Louisville, KY Association of Occupational Health Nurses (LKAOHN) is one of 2 chapters of the American Association of Occupational and Environmental Health Nurses in Kentucky. Members meet on a regular basis for networking and continuing education opportunities specific to their practice. For more information about occupational and environmental health nurses, contact the American Association of Occupational Health Nurses Inc. at (800) 241-8014 or go to www.aaoihn.org.

AAOHN is a 10,000 member professional association dedicated to advancing the health, safety and productivity of domestic and global workforces by providing education, research, public policy and practice resources for occupational and environmental health nurses. These professionals are the largest group of health care providers serving the worksite.
**University of Louisville School of Nursing Dean Outlines Vision**

“It is almost more competitive now to get into nursing school than it is to get into law school or medical school,” said University of Louisville School of Nursing Dean Marcia Hern. Hern made the comments as part of an on-campus welcome reception held in her honor this winter. “We turned away 75 highly qualified applicants who we could have easily brought into our classrooms and in clinical if we only had more faculty,” Hern noted during her speech to faculty, alummi and community nursing leaders. Dean Hern called upon hospital leaders to help create solutions to the problem by giving the school loaned faculty or creating another type of joint teaching opportunity.

The new School of Nursing leader joined UofL less than a year ago. She previously served as the Dean of Texas Woman's University College of Nursing. As part of the school's strategic plan, Hern talked about the need to bolster focus on research. “We are on a research university, therefore our nursing science must drive what we're about,” said Hern. Hern said faculty members have worked hard to secure research funding, with over 4-million-dollars in grant requests submitted just this academic year. The research focus also means a revision of the undergraduate curriculum. The Bachelors of Science in Nursing (BSN) program now includes an overarching framework of evidence-based practice. Undergraduate students will now look more closely at data all four semesters to analyze the evidence that supports their studies and practice.

The Masters of Science in Nursing (MSN) program has also been reshaped, and the PhD program is moving ahead. The school began offering a PhD program in 2005. Student Pamela Combs recently became the first student to successfully complete her comprehensive exams. She's now working on a dissertation.

The UofL School of Nursing Dean also discussed plans to update the school's building located on the university's Health Sciences Campus. Renovation goals include new carpet, new lab equipment and a new auditorium with occupancy of the fourth floor for development of the SON research enterprise. Developing more high-tech learning opportunities is also part of the plan. The school hopes to create a state-of-the-art clinical lab with more high-fidelity simulation mannequins than the existing one for some 250 undergraduate nursing students. “It's important that our students learn on the best technology,” she said.

The faculty also contribute greatly to the community through practice initiatives such as the Harambee Nursing Center, the Race Track Clinic and the Volunteer Caregivers Program. As the School of Nursing leader, Hern said she's committed to finding ways to make the school's dreams a reality, with all the help of the faculty, staff, alumni and community health care leaders.

Five University of Louisville School of Nursing faculty (Karen M. Robinson, DNS, APRN-BC, FAAN, Beth Bonham, PhD, APRN-BC, Vicki Hines-Martin, PhD, RN, BC, Celeste Shawler, PhD, RN, CS, and Kay T. Roberts, EdD, RNC, FNP, FAAN) will chair a post-conference workshop at the International Society of Psychiatric-Mental Health Nurses April 8th-12th in Louisville, KY. The workshop is entitled Community-Based Participatory Research in Action.”

University of Louisville School of Nursing professor Karen Robinson, DNS, APRN-BC, FAAN, became the inaugural Fellow of the newly created American Association of Retired Persons (AARP)/American Academy of Nursing (AAN) Joint Fellowship program. Dr. Robinson, an expert in psychiatric issues in geriatric nursing and care giving for people with dementia, will spend a year examining health policy and program planning at the AARP Public Policy Institute in Washington, D.C. The program is designed to prepare nurse leaders to play a more prominent role in health policy development at the national level. She's blogging about her experience in Washington, D.C. at http://uoflconnect.typepad.com/publicpolicyfellow/.

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When the State Board Calls: Part I Guidance from Nurse Attorney, Latonia Denise Wright

Diane E. Scott, RN, MSN

Every week, Latonia Denise Wright, R.N., B.S.N., J.D., is contacted by a nurse seeking advice about a letter or a phone call received from a State Board of Nursing or Attorney General’s Office investigator. The investigation often surrounds an allegation concerning an incident that may have occurred several months or years before the nurse is contacted.

As an attorney licensed in Ohio, Kentucky, and Indiana, Ms. Wright has often witnessed a nurse’s anxiety and panic surrounding State Board discriminatory investigations. We recently spoke with Ms. Wright, a former member of the Board of Directors of the Center for American Nurses, to help understand what to do when the State Board calls.

The Center: Why would a State Board investigate a nurse?

Ms. Wright: Many nurses may not fully realize that the role of any Board of Nursing is to protect the public from unsafe nursing care. The vast majority of nurses’ only interaction with their State Board is when they are first licensed and when it is time for their license renewal. It comes as a surprise for many nurses that their State Board of Nursing was not established to be the advocate and protector of nurses in their state, but to be guardians of the public.

The States Board of Nursing have the admirable, and often daunting task, of being entrusted to look after the public and have the responsibility to investigate the behavior of any nurse who may have allegedly violated their nurse practice act. While the process varies state-to-state, a State Board will investigate a nurse if the Board is informed of any potential violation of the statutes and regulations.

A nurse may be reported by the public, a peer or an employer. In fact, the majority of nurses practice in mandatory reporting states where employers are required to report suspected or alleged violations of the Nurse Practice Act and/or Board of Nursing regulations to the Board of Nursing.

The Center: When should a nurse contact an attorney?

Ms. Wright: While representing oneself is a nurse’s right in our justice system, it is difficult to maintain one’s composure, remain objective, and act in one’s own best interest at all times when proceeding as your own representative. Many times, a nurse will only seek legal representation after there has been irrevocable action against their licenses to practice or after the disciplinary investigation has gone off course.

If a nurse is reported to the State Board of Nursing or if an investigator calls them, it behooves them to consult with a nurse attorney who practices administrative law in their state before they provide the Board with any information via a phone interview, written statement or meet with an investigator.

Most nurses are so staggered by the initial phone call from the Board, that they do not fully comprehend the ramifications of their responses. Although the investigator’s conversations may be described as “routine” and may be rather short in length, a nurse still needs to be cautious of every response and can reserve the right to representation prior to answering any questions.

If a nurse has spoken with the state board without speaking to an attorney, it is very important that the nurse seeks legal advice prior to signing any agreements or orders. A nurse needs to fully understand the terms and provisions in any agreement or order prior to signing the document. A nurse can hire legal representation at any point in the investigative and adjudicative process or even before the actual complaint is filed with the Board of Nursing if the nurse knows or suspects a compliant will be filed.

The Center: What about the cost of an attorney?

Ms. Wright: A nursing license is how a nurse supports her family: it is her livelihood. Making an informed decision in any matter that impacts a nurse’s livelihood and State Board of Nursing disciplinary investigations and adjudications can impact a nurse’s license as well as her career.

While professional legal advice is not free, the financial, emotional, employment and professional ramifications of being investigated and facing action against a license overwhelmingly supports the expense of retaining an attorney. In many cases, a one-time phone call or in-person consultation at the cost of a few hundred dollars can help determine the need for further consultative services. What many nurses do not realize, is that their own professional liability insurance may pay for legal counsel in many cases.

The Center: Should a nurse carry their own liability insurance?

Ms. Wright: One significant means to manage exposure to liability for healthcare professionals is to purchase professional liability insurance. While many nurses are under the assumption that their hospital’s malpractice policy provides adequate protection, I cannot emphasize enough that an employer’s liability policies are meant to protect the facility.

By owning a professional liability insurance policy, a nurse is protected in the event they are named as a defendant in medical malpractice and in the event a complaint is filed against their license with the Board of Nursing.

When purchasing a policy, make sure that it covers attorney fees and costs in State Board of Nursing disciplinary investigations. Nurses should consider purchasing an insurance policy for an insurer that writes policies for nurses and other licensed healthcare professionals as this typically may include coverage for professional liability, licensure defense, and deposition representation.

The Center: In closing, how do I find a licensed attorney?

Ms. Wright: Contact your state nurses association for a referral to a nursing licensure attorney (www.nursingworld.org), or contact The American Association of Nurse Attorneys (www.taana.org).

This Nursing That Works article is not intended to take the place of any professional legal advice. For more information, please contact your State Board of Nursing, state nurse’s association, or contact a licensed attorney. Do not wait to hire an attorney once you are licensed.

LaTonia Denise Wright, R.N., B.S.N., J.D. is licensed to practice law in Ohio, Kentucky, and Indiana and is a Registered Nurse in Ohio. The majority of her law practice involves defending nurses in licensure matters. She currently practices as an RN with Interim HealthCare in Cincinnati, Ohio on a per diem basis. Her blog about the law, legalities, and legal issues in nursing is www.advocatenurses.typepad.com.

The next issue of Nursing That Works will present an interview with an Executive Director of a State Board of Nursing.
WELCOME NEW MEMBERS

The Kentucky Nurses Association welcomes the following new and/or reinstated members since the January/February/March 2008 issue of the KENTUCKY NURSE.

**District #1**
- Charlotte F. Beason
- Cheryl A. Bray
- Karima M. Gilmore
- Robin A. Lanning
- Shannon M. Morris
- Melody D. Reibel
- Jean A. Stodghill
- Shirley M. Vittow

**District #2**
- Regina L. Angel
- Holly M. Bell
- Carol L. Broughton
- Linda Clements
- Marcella Crawford
- Bobbie M. Damron
- Linda L. Dempsey-Hall
- Jennifer L. Forman
- Angela Graham
- Jessica Higgin
- Connie L. Hubbard
- Theresa D. Loan
- Susanna L. Moberly
- Carla L. Sanders
- Nadia M. Shipp
- Lori A. Skaggs
- Judy B. Wade
- Timothy E. Winterfeld

**District #3**
- Deborah S. Cummings
- Julianna Osseo
- Darla K. Schwenke
- Babethte D. South
- Laura J. Tolson

**District #4**
- Ruth H. Johnson
- Susan Mudd

**District #5**
- Donna J. James
- Vanessa E. Lyons
- Shay L. Robertson

**District #6**
- Chadwick W. Adams
- Christa Ashington
- Donna G. Anderson
- Katrina Atkinson
- Angela K. Ausmus
- Ethel S. Ball
- Samantha Ball
- Elizabeth A. Bargo
- Tracey R. Barnett
- Tommy Becher
- Sharon Blair
- Brittany Boggs
- Suprina Boggs
- Tiffany Boggs
- Rhonda Bush
- Nicole R. Buttreys
- Margie Byrd
- Deborah Caudill
- Mary Ellen Clayton
- Jennifer R. Clevinger
- Lizzie Collett
- Melissa Collett
- Amy E. Cook-Combs
- Virginia Coach
- Rena Davidson
- Thomas A. Elswick
- Heath Faulkner
- Johnathan L. Fowler
- Rebecca A. Francis
- Auros N. Frye
- Lara A. Galloway
- Wanda S. Garland
- Doris Gibson
- Kimberly N. Gidcumb
- Alice Faye Gilley
- Krissey Michelle Grindstaff
- Joyce L. Griffith
- Mary Jo Haddox
- Michelle Hembree
- Karen Holland
- Bonnie Hill Howard
- Sarina Huff
- Vanessa Lynn Little Isaac
- Rainey Kaye Jackson
- Monica L. Johnson
- Lori Ann Khack
- Deanna Leath
- Ashley B. Lindsey
- Donna Lloyd
- Sheila A. McArthur
- Tasha Mc Clees
- Karen P. Meadows
- Stephanie Melton
- Whitney M. Melton
- Barbara Middleton
- Jennie Dianna Miles
- Bertha Lou Miller
- Maudie Minard
- Jessica Vanover Napier
- Connie Sue Owens
- Pamela Pace
- Anthony W. Powers
- Charity Rader
- Kristen D. Richerson
- Starlett Stewart
- Cher-Larue Swaggerty
- Denise E. Tackett
- Carla M. Thomas
- Suzette Trent
- Kristen Rose Watkins

**District #7**
- Kim Botner
- Toshia E. Calvert
- Sheila F. Calliet
- Ann W. Christie
- Amanda F. Costello
- Radella J. Gibson
- Marita A. Hockstedler
- Elizabeth S. Huber
- Mary F. Kovar
- Anne M. Leonard
- Ashley B. Lindsey
- Lori A. Skaggs
- Lisa E. Stewart

**District #8**
- Alysse M. Alexander
- Lois A. Morgan
- William H. Shelton
- Tina L. Snodgrass
- Eunice K. Taylor

**District #9**
- Reylinda J. Meyer
- Laura L. Terrell

**District #10**
- Rita Allen
- Angela M. Budd
- Tanya Elvina Carty
- Kara Elam
- Peggy S. Fisher
- Deatra Gillespie
- Teresa Hall
- Cynthia Lyons
- Tina Prater
- Robin Robbins
- Therese M. Sirels

**District #11**
- Rebecca H. Keith
- Patricia M. Logsdon
- Gloria J. Wacks

**Kentucky Nurses Association Calendar of Events 2008**

**April 2008**
- 4 10:00 AM Finance Committee
- 14 1:30 PM Convention Program Planning Committee
- 17 1:00 PM KNA Board of Directors
- 22 1:30 PM Education & Research Cabinet

**May 2008**
- 5-9 HAPPY NURSES WEEK
- 15 7:00 PM District 4 Meeting
- 22 2:30 PM Nursing Practice & EPS Cabinet, Elizabethtown (TBA)
- 26 KNA Office Closed Memorial Day Holiday
- 30 Materials due for the July/August/September issue of Kentucky Nurse

**June 2008**
- 6 1:00 PM Editorial Board (Location TBA)

**July 2008**
- 1 Materials due for the Call to Convention 2008
- 4 KNA Office Closed Fourth of July Holiday
- 18 Materials due for the October/November/December Issue of Kentucky Nurse

**September 2008**
- 1 KNA Office Closed Labor Day Holiday

**October 2008**
- 15-17 KNA Convention 2008 (Louisville Marriott East)

**All members are invited to attend KNA Board of Directors meetings (please call KNA first to assure seating). Call KNA for information on meeting location, time and date.**
Please type or print clearly. Please mail your completed application with payment to Kentucky Nurses Association (KNA), P.O. Box 2616, Louisville, KY 40201-2616.

Last Name/First Name/Middle Initial

Home Address

City/State/Zip Code + 4

County

E-Mail Address

Membership Category

Payment Plan (please check)

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<th>Payroll Deduction</th>
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<td>Check (Payable to KNA)</td>
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Select your KNA District from the map.

Date

Home Phone Number

Basic School of Nursing

Cell Phone Number

Fager Number

Graduation (Month/Year)

Would you like to receive KNA email updates with important information relative to nursing and healthcare?  Yes ☐ No ☐

Employer

RN Licensure Number/State

Membership Category

| Full Membership: $529.00 Annually or $43.75 Per Month |
| Assoc. Membership: $519.50 Annually or $42.96 Per Month |
| Special Membership: $599.75 Annually or $49.98 Per Month |

Associate Membership: $69.75 Annually or $6.31 Per Month

Employed part-time

Employed full-time

New graduate from basic nursing education program within six months of graduation (first membership year only)

Full Membership: $279.00 Annually or $23.75 Per Month

Employed part-time

Employed full-time

Special Membership: $539.00 Annually or $44.08 Per Month

Full Annual Payment

Payroll Deduction

Full Annual Payment

Payroll Deduction

KNA Member

Presentation

Mailing/Publication

Note: State nurses’ association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense.

Under Kentucky Law, that portion of your membership dues used by KNA for lobbying expenses is not deductible as an ordinary and necessary business expense. KNA reasonable estimates that the non-deductible portion of dues for the 2006 tax year is $98.74.

In an actively licensed RN

<table>
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<th>I heard about KNA from</th>
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Full Annual Payment

Payroll Deduction

KNA/ANA’s charter is to influence the health care environment for the benefit of all Kentuckians through lobbying action...full-time RN who is not currently employed as a nurse due to disability

KENTUCKY NURSES ASSOCIATION MEMBERSHIP APPLICATION

1400 South First Street, P.O. Box 2616, Louisville, KY 40201-2616

(502) 637-2546 * (800) 348-5411 * Fax: (502) 637-8236

www.kentucky-nurses.org * Contact@kentucky-nurses.org

Rolling Deduction Authorization Signature

Bank Card Numbers

Expiration Date

Amount

Authorized By

Printed Name

To Be Completed by KNA/ANA

Employee Code

State

District

Approved By

Expiration Date

Amount Received

Check #

*By signing the Epay or Annual Credit Card authorizations, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Above signed may cancel this authorization upon receipt by ANA of written notification of termination (within) (30) days prior to the deduction date designated above. Membership will continue unless this notification is received. ANA will charge a $5 fee for any returned drafts or chargebacks.

**Monthly epay includes $5.50 service charge (effective 1/2004)