Kansas Governor Proclaims 2012 as the Centennial Year of the Kansas State Nurses Association

The Voice and Vision of Nursing in Kansas
March-April 2012 Contents

3. State of Kansas Proclamation signed by Governor Sam Brownback
4. From KSNA President Sandra Watchous, MN, RN
5. From KSNA Executive Director Terry Leatherman
6. From KSNA Legislative Chair Sarah Tidwell, MS, RN
8. From KSNA Office
9. Welcome New KSNA Members, Dates & Deadlines
10. KSNA Centennial Planning Committee
11. 2012 KSNA Nomination Form for Statewide Elections
12. From the Districts: District 2, District 6 and District 17
14. Sedation of the Ventilated Patient by Louisa M. Golay, RN, BSN
17. Nurse Practitioner’s Role in Providing Evidenced-Based Research on Childhood Vaccines by Tonya Stallbaumer, RN
19. Improving Patient Outcomes: Reducing the Risk of CAUTIs by Dannielle Finan, RN, MSN, CNL

On the cover (L-R): KSNA members Carol Gaumer, Lawrence; Carolyn Middendorf, Topeka; Lynn Skinner, Perry; Shirley Dinkel, Topeka; Marian Jamison, Topeka, Kansas Governor Sam Brownback; Naomi Nibbelink, 90, Topeka (seated); Carla Lee, Wichita; Diane Glynn, representing the Kansas State Board of Nursing; President Sandy Watchous, Hays; Mary Holland, Ottawa. Proclamation signed January 27, 2012, at the State Capitol.

Mission Statement
The Kansas State Nurses Association promotes professional nursing, provides a unified voice for nursing in Kansas and advocates for the health and well-being of all people.

Submission of Articles
Interested authors should send their written material to KSNA for review prior to possible publication. Electronic submission is preferred with “For Publication in TKN” in the subject line of an email addressed to ksna@ksna.net. Please provide the author’s complete contact information. A confirmation note will be sent to the submitting author and the article submitted will be peer reviewed. Any decision regarding publication will be forwarded to the author. Questions regarding the process may be directed to KSNA at 785-233-8638 or ksna@ksna.net

KSNA is a Constituent Member Association of

Kansas State Board of Nursing (licensing) 785-296-4929
Kansas Nurses Assistance Program 913-236-7575
Kansas Tobacco Quitline 866-KAN-STOP
STATE OF KANSAS

PROCLAMATION

by the
GOVERNOR

TO THE PEOPLE OF KANSAS, GREETINGS:

WHEREAS, on February 8, 1912, a group of nurses determined to form an association of registered professional nurses, founded the Kansas State Nurses Association; and,

WHEREAS, the primary purpose of the first founders was to organize so as to promulgate law for the legal practice of nursing, so accomplished by 1913, the year the Kansas State Board of Nursing was established; and

WHEREAS, KSNA has 1100 members that represent the leading and largest organization speaking to health issues that affect nursing and its role in the delivery of safe, quality, and cost-effective health care; and

WHEREAS, the Kansas State Nurses Association is a constituent member of the American Nurses Association founded in 1896, the nation's leading nursing organization, serving as the voice for 3.1 million registered nurses in America; and

WHEREAS, KSNA, being voted the most trusted profession in America, serves as the key advocate for the delivery of quality health care in our state;

NOW, THEREFORE, I, Sam Brownback, GOVERNOR OF THE STATE OF KANSAS, do hereby proclaim 2012, as the

Centennial Year of the Kansas State Nurses Association

in Kansas and urge all citizens to acknowledge the importance of the accomplishments of nurses in the State of Kansas.

DONE: At the Capitol in Topeka under the Great Seal of the State this 27th day of January, A.D. 2012

BY THE GOVERNOR:

[Signature]

Secretary of State

[Signature]

Assistant Secretary of State
Recruitment! Retention! Recognition! Relevance! In school we had the 3 R’s, now we have the 4 R’s that guide our activities and decisions at the district, state, and national levels. Just as the states are the building blocks for ANA, the districts are the building blocks for KSNA. The members recruited at the District level benefit KSNA and the members recruited at the State level benefit ANA. In turn, the recruiting at the ANA level benefits KSNA and the members recruited at the state level benefit the districts. We are all interrelated and interdependent. Each level must look at the needs of the other levels and provide support whenever and wherever possible.

To aid in recruitment, the membership committee has developed a basic plan to assist districts with activities and maintaining their function. The plan includes sample by-laws which provide a simple governance structure. To help with meetings, KSNA is developing a speakers’ bureau with individuals who are available to speak on a wide variety of topics at district and state meetings. To facilitate board meetings, KSNA has two conference call lines available if districts would like to hold board meetings by conference call. The lines may be scheduled for use by contacting the KSNA office.

At the national level, ANA continues their strategic planning process focused on rapidly developing an integrated package of bold changes to achieve a recharged organization with modern governance structures and focused strategic operations which will lead to a robust future for ANA. They have identified six important elements needed for this transformation. These include simplified governance, strengthened infrastructure through unification, strengthened staff support for state-based activities, high growth membership framework, rationalized and simplified product and service structure, and an integrated technology platform. Achieving this plan has required ANA to eliminate some positions such as the Chief Operating Officer and to create others such as an Information Technology Department. With these changes ANA will be stronger and able to provide more support to the State Associations.

There are other changes planned at the national level such as reducing the size of the Congress of Practice and Board of Directors. These changes which have pros and cons will come before the House of Delegates this summer. Other changes include holding meetings by phone conference, and in some cases reducing the number of meetings. At the state level, KSNA is revisiting the policies and procedures as well as KSNA documents such as By-Laws, membership manual, and forms to bring them into compliance with ANA By-Laws and other requirements. I have turned to many individuals including members, CPAs, attorneys, and bankers, to learn and understand the laws, regulations, decisions, and best practices that govern professional organizations. In the process I was guided to a book Association Law Handbook by Jerald Jacobs which provides sample documents covering governance and transaction topics. If any district has questions about bylaws or procedures they are using this book is a great resource and I will be happy to share the information. Input from members is welcomed in this process and you may obtain copies of current documents by contacting the KSNA office.

Everyone is encouraged to submit their names for open positions at the district, state, and national levels and to submit nominations for awards at all levels. This year will be the beginning of the Wall of Fame Award which is part of the Decade of the Nurse plan. The first awards will be presented at the Centennial Convention.

Our Centennial Year got off to a great start with a Proclamation, banquet, and DATL. We appreciate all of those who attended the activities, the great work of the planning committee, and the comments that were submitted. We are looking forward to the Centennial activities planned in the months ahead.

We have recently learned that KSNA received a $70,000 grant from the Heritage Trust Fund to repair the roof of our beautiful building. We continue to work on meeting fire codes for the City of Topeka so we can begin looking for ways to utilize our building. Please feel free to call me anytime and to share your thoughts and ideas. Have a great spring and enjoy the flowers.

(Note: unedited)
From the KSNA Executive Director

Terry Leatherman
KSNA Executive Director

KSNA’s Home Awarded Historic Preservation Grant

The Kansas State Nurses Association, which is celebrating its 100th year as the voice and vision of nursing in our state this year, is very fortunate to make its home in an historic Topeka landmark building. In February, KSNA learned the Kansas Historical Society wants to help preserve our building when KSNA was awarded a Heritage Trust Fund Grant.

KSNA’s headquarters is in the “Crosby House,” which was built more than 100 years ago by Topeka businessman, William Crosby. The historic structure is listed on the state and national Registers of Historic Places. However, after a century of use, the building is in need of significant and costly repairs. At the top of the list of repairs needing immediate attention is preserving the structure through restoring the home’s clay tile roof. That costly work can now begin, thanks to the Heritage Trust Fund Grant.

KSNA was awarded $70,700 to be expended towards roof restoration of the Crosby House. Overall, the Kansas Historical Society approved 24 grant requests for slightly less than $1.1 million. The historic significance of a property and the urgency of repair needs were the key issues weighed by the Historical Society in awarding grants. In addition, there was an effort to see that the benefits of their grant program are seen across the state.

The plan would be to seek formal bids for the repair of the roof to the Crosby House this spring. It can also be anticipated that the restoration work will happen this calendar year. When the integrity of the roof is assured, improvements to the interior of the Crosby House can move to center stage, with the hopes of making the “Crosby House” an extremely attractive and functional association headquarters. With its location in the ‘hub of Kansas state government’, within a few blocks of the Kansas Statehouse and all the state office buildings, the KSNA headquarters building will now have a long future in downtown Topeka.

KSNA’s effort to seek the Heritage Trust Fund grant has been spearheaded by KSNA President Sandy Watchous. Congratulations to Sandy and the KSNA Board of Directors for successfully securing the support of the Kansas Historical Society. Now comes the exciting part. From the building we work in to the work we are doing each and every day, the Kansas State Nurses Association is getting stronger and stronger.
From the KSNA Legislative Chair

Sarah Tidwell, MN, RN
KSNA Legislative Chair

KSNA 2012 Legislative Priorities

1. Support efforts to improve the ability of Registered Nurses in Kansas to adequately provide mental health services.
2. Support adequate funding for the Kansas State Board of Nursing and preservation of licensure services.
3. Advocate for legislation that protects and promotes the 2010 Kansas Indoor Clean Air Act.

2012 Legislative Activity

KSNA provided written testimony to the Social Services Budget committee expressing safety concerns for nurses working overtime because of staffing shortages, particularly at Larned State Hospital. The testimony cited evidence-based practice recommendations related to shift duration and the number of work hours during a week that have been published by the Agency for Healthcare Research and Quality. These recommendations include that nurses: (1) not work more than three shifts without a day off; (2) that provisions are made for sufficient staffing to ensure the nurse is free of patient care responsibilities for 10 minutes every 2 hours and for 30 minutes to eat a meal; and (3) that the nurse have at least 10–12 hours off between shifts so that they can obtain sufficient sleep.

The Governor’s budget that was published in January included an increase of 4 FTE’s in the Board of Nursing budget to accommodate the move of licensing and credentialing of Certified Nurse Aides, Certified Medication Aides, Home Health Aides, and the Nurse Registry to the Board of Nursing. However, the Governor’s Executive Reorganization Order released on February 3rd moves the credentialing and registry to the new Department for Aging and Disability Services. The additional FTE’s will be removed from the Board of Nursing’s budget and keep the Board at it’s current 24 FTE’s.

Several bills have been recently introduced that would weaken the Clean Indoor Air laws. HB 2690, termed the Smoking Premises Bill, would provide that any private business or nonprofit organization could allow smoking on its premises as long as employees and patrons were at least 21 years of age and as long as proper signage was posted. This bill would open a variety of bars, taverns, possibly restaurants and other recreational facilities to have age restrictions in place and smoking privileges.

SB 340 would extend membership privileges (including drinking and smoking privileges) for anyone wanting to join a Class A veterans’ association club. HB 2521 would eliminate the penalties for tobacco and alcohol civil violations, if no action is taken within the first 90 days after the violation occurs. Concern is that this bill could impact Kansas compliance with the Master Settlement Agreement provisions. Finally, HB 2324 is supported by KSNA as it would make it unlawful to furnish electronic cigarettes to people less than 18 years of age and would place violations of e-cigarette sales to youth and the possession of e-cigarettes by a minor under the same penalty provisions as those for cigarettes and tobacco products.

Constant vigilance is needed to combat attempts to weaken Clean Indoor Air in Kansas. Please contact your Representative/Senator and express your views on these bills.

Committee member contact information is available at www.ks.legislature.org

Kansas State Board of Nursing

Notice of Hearing
On March 20th, the Kansas State Board of Nursing will conduct a hearing on proposed changes to APRN and LPN IV Therapy regulations. The proposed regulations are available for review on the KSBN website. The hearing will be held at 1:30 p.m. in Room 1051 of the Landon State Office Building. All interested parties may participate in the hearing by presenting their views orally or in writing. Written comments
should be submitted prior to the hearing to the Executive Administrator of the Board of Nursing, 1051 Landon State Office Building, 900 SW Jackson, Topeka KS 66612. Telephone comments will also be taken by calling 877-278-8686 (access code 904252) at 1:30 p.m. on the day of the hearing.

**Titling for Advanced Practice Nurses**

As of January 1, 2012, the only Kansas legal requirement is the signature with APRN. It is recommended by the APRN Consensus Model that all advanced practice nurses are to use the initials APRN behind their name followed by their role and then certification. For example,

- B. Jones, APRN, FNP-BC
- B. Jones, APRN, PMHCNS-BC
- B. Jones, APRN, PMHNP-BC
- B. Jones, APRN, ACNP-C
- B. Jones, APRN, CNS-BC
- B. Jones, APRN, CNM
- B. Jones, APRN, CRNA

**ANA Files Amicus Brief**

Press release from ANA

The American Nurses Association joined five other health care groups representing millions of health care professionals in filing an amicus brief with the U.S. Supreme Court in support of the Affordable Care Act's (ACA) “minimum coverage provision.” The cost of this uncompensated care is distributed to other patients or to government health programs such as Medicare or Medicaid. According to one study, this cost shifting adds, on average, $410 to each individual insurance premium and $1,100 to each family premium. “We need to preserve the provision in the law that spreads risks and costs fairly and allows us to provide more effective, less expensive health care for all Americans,” Daley said.

ANA contends that many of the fundamental reforms provided by the ACA, such as prohibiting denial of health insurance based on pre-existing conditions, greatly improve access to health care. These patient protections will not be feasible financially without a minimum coverage provision. The provision is essential to the ACA’s goal to make health insurance universally available and affordable. ANA believes that health care is a basic human right, and that all individuals should have access to essential health care services.

**Opportunity for Public Comment**

ANA is requesting public comment on the following two draft documents. The documents and methods for submitting comments are located at: www.nursingworld.org/Main-MenuCategories/ThePracticeofProfessionalNursing/Callfor-

**Principles for Delegation by RNs to UAPs**

This document is a major revision of the 2005 document, focusing on delegation to unlicensed assistive personnel, and includes a revised Decision Tree for Delegation. The deadline for comments to be submitted is March 16, 2012 by close of business.

**Care Coordination and Nurses’ Essential Role**

This position statement articulates the essential role of the RN in the care coordination process. The dual goals of health reform, quality improvement and cost control, are largely reliant on effective coordination of patient care. Comments will be received until Thursday, March 15 at 5 p.m. ET

**National Nurses Week**

In promoting the 2012 National Nurses Week, May 6-12, the American Nurses Association (ANA) and its members have selected the theme “Nurses: Advocating, Leading, Caring.” The selected logo (above) has been selected to promote the annual week.

Often described as an art and a science, nursing is a profession that embraces dedicated people with varied interests, strengths, and passions because of the many opportunities the profession offers. Nurses serve in all of these roles -- from staff nurse, to educator, to nurse practitioner, and to nurse researcher -- and serve all of them with passion for the profession and with a strong commitment to patient safety.

May 6 is known as National Nurses Day and May 12 is the birthday of Florence Nightingale, founder of modern nursing. Visit the ANA website -- nursingworld.org -- for more information about how you and your district can celebrate this important week. And, please let the KSNA office know of your plans; photos of district activities are encouraged.
The following KSNA leadership positions are open for nomination this year. Please refer to the Bylaws, Article IV and Article V. Each candidate must complete a 2012 KSNA Nomination Form which may be downloaded from the KSNA website at ksnurses.com and mailed to the KSNA office by April 30.

- President-elect & ANA Delegate at Large (4 yrs)
- Secretary (2 yrs)
- 2 members of the Board of Directors (3 yrs)
- 3 members of the Nominating Committee (1 yr)
- 4 members of the Council on Economic & General Welfare (2 yrs)
- 3 members of the Council on Economic & General Welfare Nominating Committee (1 yr)

Members of the 2012 Nominating Committee are Chair Patricia Joyce (District 1), Sonya Curtis (Federal Nurses & District 1), Carla Lee (District 6) and Kathy Neely (District 6). Members of the Economic & General Welfare Nominating Committee are Terri Roberts (District 1) and Laura Sidlinger (District 1).

**KSNA Dues Tax Deductible**

The Omnibus Reconciliation Act of 1993 requires KSNA to notify members that the percentage of KSNA/ANA dues which is allocated to lobbying expense is not deductible as an ordinary and necessary business expense for federal income tax purposes. The KSNA estimates that the non-deductible portion of 2011 KSNA/ANA dues which are allocated to lobbying expenses is 10.95 percent. The deductible amount is $252.

**Educational Expenses Tax Deductible**

Treasury Regulation 1.162-5 permits an income tax deduction for education expenses to include registration fees, costs of travel, meals, and lodging undertaken to maintain or improve skills required in one’s employment, other trade, or business. Registered nurses attending continuing education courses are permitted to itemize the expenses and report them on Schedule A, line 20, and claim the expenses as deductions.

**2012 KSNA Resolutions**

A resolution is a call for action on a subject of great importance to the member organization and is formally written. The KSNA Resolutions Committee stands ready to mentor individuals and groups who want to draft a resolution this year. The 2012 Resolutions Committee, chaired by Ken Sisley (District 18) includes Janet Ahlstrom (Board Liaison), Delyna Bohnenblast (District 21), Michele Hinds (District 2), Carla Lee (District 6) and Naomi Nibbelink (District 1). The Resolutions Policy and Procedures are located on page 14 of this issue or on the KSNA website. The deadline for submitting resolutions to the KSNA office is June 30.

**2012 Nominations for KSNA Awards & Recognition**

It is not too early to start considering your fellow KSNA members who are worthy of recognition at the next KSNA Annual Convention -- this year, our Centennial Convention. Information about KSNA’s annual awards are published in this issue on page 15 and are available on the KSNA website. To nominate someone, provide a written statement of the nominee’s value to nursing in Kansas and what they have specifically done to deserve the award. The deadline for receiving most award nominations at the KSNA office is June 30; the deadline for Honorary Recognition nominations is July 31.

**In Memoriam**

Barbara J. McPherson, RN, died February 18 at Great Bend. She was 81 years old and a graduate of the University of Kansas School of Nursing. She was appointed to the Kansas State Board of Nursing, 1991-1995, and served two years as its president. She was a member of KSNA District 7 and had served in several leadership roles.
Welcome
New KSNA Members
Applications Received
January and February 2012

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<tr>
<th>District</th>
<th>Name</th>
<th>City</th>
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<tr>
<td>1</td>
<td>Lori Jo Bacon</td>
<td>Tecumseh</td>
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<td>1</td>
<td>Debbie Hedges</td>
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<td>1</td>
<td>Rendilyn Kersting</td>
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<td>1</td>
<td>Heather Sleichter</td>
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<td>2</td>
<td>Kavita Desai</td>
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<td>2</td>
<td>Vincent Juliano</td>
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<td>2</td>
<td>Stephanie Kimbrel</td>
<td>Olathe</td>
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<td>2</td>
<td>Margaret Monahan</td>
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<td>2</td>
<td>Lawrence Owino</td>
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<td>Janet Pierce</td>
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<td>Lisa Powell</td>
<td>Basehor</td>
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<td>Meagan Krueger</td>
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<td>Mindy Lovendahl</td>
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<td>5</td>
<td>Kenneth Smith</td>
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<td>6</td>
<td>Kim Bieler</td>
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<td>6</td>
<td>Sara Bobbitt</td>
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<td>6</td>
<td>Kristen Knowles</td>
<td>Derby</td>
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<td>6</td>
<td>Laura Oman-Poole</td>
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<td>Ivonne Rivera-Newberry</td>
<td>Maize</td>
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<td>Angela Walker</td>
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<td>Kary Przymus</td>
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<td>Cindy Groene</td>
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<td>Rachel Lucas</td>
<td>Towanda</td>
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<td>Stephanie O'Neil</td>
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<td>Erin Krause</td>
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<td>Sheila Raaf</td>
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<td>Janae Eberle</td>
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<td>15</td>
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<td>WaKeeney</td>
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<td>16</td>
<td>Mary Jo Gubitso</td>
<td>Hays</td>
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<td>17</td>
<td>Roxy Johanning</td>
<td>Berryton</td>
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<tr>
<td>21</td>
<td>Jody Stritzke</td>
<td>Coffeyville</td>
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Explore KSNA at ksnurses.com

Dates & Deadlines

March 12  KSNA Centennial Committee Conference Call-7 pm
March 24  KSNA Board of Directors meeting, Topeka
March 27-28  Kansas State Board of Nursing Meetings, Topeka
April 16  Editorial Deadline for May-June 2012 Issue of The Kansas Nurse and KSNA Centennial Committee Conference Call-7 pm
May 5  KSNA Board of Directors meeting, Topeka
May 6-12  National Nurses Week
May 7  Centennial Committee Conference Call-7 pm
May 25 & 28  KSNA Office Closed, Staff Vacation Day & Memorial Day
June 11  Centennial Committee Conference Call-7 pm
June 12-13  Kansas State Board of Nursing Meetings, Topeka
June 13-16  ANA House of Delegates Meetings National Harbor, MD
July 2-6  KSNA Office Closed, Staff Vacation & Fourth of July
July 9  KSNA Centennial Committee Conference Call 7 pm
July 14  KSNA Board of Directors meeting, Topeka
August 25  KSNA Board of Directors meeting, Topeka
August 27  KSNA Centennial Committee Conference Call-7 pm
KSNA Centennial Planning Committee

The following KSNA members are involved this year in planning the organization’s 100 years anniversary celebration. Thank you for your enthusiasm and interest in making 2012 a very special year for KSNA and its members. Please join in recognizing and applauding their efforts.

Chair & Board Liaison
Linda Luzier, District 4  316-283-5075  nurseLinda2012@live.com
Susan Bumsted, District 6  (316) 721-6325  slbumsted@cox.net
Martha Butler, District 10  620-221-0282  martha.butler@sckans.edu
Sonya Curtis, District 1/FNA  316-207-8410  sonya.curtis@va.gov
Emma Doherty, District 5  785-827-2478  doherty@midkan.net
Ronda Eagleson, District 4  316-804-4439  reagleson1@cox.net
Christina Ellis, KANS  316-210-0866  christina.ellis@sckans.edu
Jackye Feldman, District 10  620-229-9895  jfeldman10@cox.net
Angella Herrman, District 2  913-940-3071  angella.herrman@hotmail.com
Duane Jaeger, District 6  316-264-2778  duane.jaeger@med.va.gov
Janice Jones, District 10  (316) 321-9919  jjones@butlercc.edu
Carla Lee, District 6  316-213-7865  adxlee@newmanu.edu
William (Butch) Luzier, District 4  620-327-2442  cubbre@hughes.net
Michael Nelson, District 13  816-261-1102  ksbearcat@gmail.com
Pat Plank, District 6  316-293-7172  pjplank@yahoo.com
Margaret Sams-Dillon, District 2  913-894-6735  marjdillon@everestkc.net
Lynn Skinner, District 17  785-597-5160  lynn.skinner@lmh.org
Gaye Stach, District 7  620-663-2358  stachg@hutchcc.edu
Serena Stutzman, District 2  913-220-4928  istuz-sw3nursingworld@yahoo.com
Sandy Watchous, District 16  785-623-9755  phhsswa@ruraltel.net
Dawn Zimmerman, District 6  620-488-3577  dzimmerman3@kumc.edu

Upcoming Committee Conference Call Meetings
Telephone Number 1-641-715-3200
Call Code 594321#

March 12, 7 p.m.
April 16, 7 p.m.
May 7, 7 p.m.
June 11, 7 p.m.
July 9, 7 p.m.
August 27, 7 p.m.
September 10, 7 p.m.

October 11-13, Centennial Convention
Marriott Hotel, Wichita
2012 KSNA Nomination Form for Statewide Elections  
(To be completed by the nominee; deadline April 30) 
Yes, I want to be considered for a KSNA leadership role at the State level. Place my name on the ballot.

Biographical Information (please print)
Name_________________________________________ Credentials_________________________________
Home Address_________________________________ City, State, Zip______________________________
Current Employer______________________________ Position Title_______________________________
Home Phone__________________________________ Work Phone________________________________
Cell Phone____________________________________ Fax Number________________________________
Email Address_________________________________ KSNA District Number________________________

Nursing Education (Name of Institution, City/State, Degree Received)
Associate________________________________________________________________________________
Diploma___________________________________________________________________________________
BSN_______________________________________________________________________________________
Masters___________________________________________________________________________________
Doctorate________________________________________________________________________________
Other Degrees__________________________________________________________

Professional Nursing Experience
Past Position
Job Responsibilities___________________________________________________________
Areas of Expertise__________________________________________________________
Areas of Interest____________________________________________________________

KSNA Offices Held (Position and Years, current and past)
National (ANA)_________________________________________________________________________
State (KSNA)___________________________________________________________________________
District (Local)________________________________________________________________________

Other Professional Nursing Activities (Organization, Position and Years)
____________________________________________________________________________________
____________________________________________________________________________________

Position Desiring
___President & ANA Delegate At Large
___Secretary
___Board of Director

___Nominating Committee
___Council on Economic & General Welfare*
___Nominating Committee, Council on E & G W*

*Must meet the definition of “non-supervisory,” within the meaning of the National Labor Relations Act to run for these positions.

Consent to Serve: I consent to have my name placed on the KSNA ballot and am willing to actively participate if elected and to assume financial responsibility for my participation.

Signature____________________________________ Date Signed________________________________

Send to KSNA, 1109 SW Topeka Blvd, Topeka KS 66612; FAX 785-233-5222 or Email ksna@ksna.net
From the KSNA Districts

District 2

President Angella Herrman reports that District 2 has been very busy and will sponsor a booth at the University of Kansas Lessons From Legends event on March 9. In addition, they collaborated with the Kansas APRN Task Force to hold a continuing education program for nurses on March 6 at the University of Kansas Medical Center. The event, “Update on Kansas NP Regulations,” presented by KSNA member and President of the Kansas State Board of Nursing Serena Stutzman, was so well promoted that the location had to be moved to a larger facility at the KU School of Nursing.

District 6

President Carla Lee reports that District 6 will hold its annual Spring meeting on April 24 at the Beech Conference Center, Wesley Medical Center, 550 N. Hillside, Wichita. Light refreshments will be served beginning at 6 p.m. with the CNE program, “Leading Change & Advancing Health” presented by Wesley Chief Nursing Officer Kathy Neely, starting at 7 p.m. The annual meeting for District 6 will be held on June 5; more information will be available closer to the date.

District 17

President Carol Gaumer reports that District 17 has been brainstorming ideas on how to capture some of the rich history of nurses in their region. They have begun to contact former district officers and asking them about their involvement in KSNA and District 17. They are also planning to hold some small group events to provide opportunities for connections between KSNA members, District members and prospective members. District 17 coordinated volunteers for the recent Lawrence Memorial Hospital Health Fair and checked the blood pressure of 126 Lawrence residents.

To Recognize our Great Nurses in 2012

HONOR YOUR SPECIAL NURSE
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The authors pose the question, “Why retire?” After all, retirement has not always been a feature in American life; people used to stop working only when they died or became physically unable to work. The concept of retirement, or life without work, really only became a concept in American life after World War II when Social Security came into being. People were mandated to stop working at age 65 in order to make room in the workforce for younger workers who needed jobs. It provided a minimum income for persons at this age so that they would not go hungry or homeless. In our time, many people are living past the age of 65; many are still in good health and could work. Retirement has come to mean a time when one can devote one’s time to leisure activities which one could not indulge while working. Many people have pension plans to finance their retirement. But many still want to contribute to society and have knowledge and wisdom derived from many years of experience. Recently, the security of carefully planned pension accounts has dwindled with the downturn of the economy and people find that they must continue to work in order to live comfortably into their extended post 65 years.

In nursing, this issue is of particular importance since there is a shortage of nurses and many nurses are expected to reach retirement age during the next few years with inadequate numbers of new nurses to replace them. Bowers and Sadler address this group of nurses who have just retired or are about to retire. Nurses who have left their primary place of employment and are still interested in nursing or find that they must continue to work for financial reasons are what the authors call “Third Age Nurses.” These nurses still love nursing, and have considerable knowledge and experience but want to get away from the strenuous demands of their current jobs and inflexible schedules.

What the authors propose is that both nurses and institutions hiring nurses assess their needs, strengths, and limitations to the end that institutions can make use of the knowledge and experience of senior nurses and these nurses can continue to be productive in satisfying ways that can help to alleviate the nursing shortage. The book is very practical and is filled with lists of things that both nurses and institutions can do to bring more senior nurses into this Third Age. Studies which have been done suggest that older nurses will remain in the workplace if they have economic incentives, have a supportive environment with fewer strenuous physical demands, are given opportunities for learning and personal development, and receive assistance in planning a transition into retirement which will make working longer more attractive. Some hospitals are providing matching funds for investment in 401a funds which increase as the years of service increase, paid time off for care-giving, and retaining full benefits for persons working 20-30 hours per week. Hospitals may also allow employees to work fewer hours and even do some work at home, share job positions, and have seasonal leaves with full benefits. They suggest new roles for senior nurses such as mentors, preceptors, technology facilitators, team builders or coaches, safety officer, staff developer, patient educator for patients and families, and facility advocate. The aim of the authors is not only to bring some of the senior nurses back into the workplace, but to encourage both current nurses and facilities to plan for future retirement.

Studies have revealed that many nurses will need more education in order to gain access to employment which satisfies both the needs and desires of our senior nurses. Nurses must plan for that education prior to retirement from their Second Age job so that they will be ready. There are lists of resources (including email addresses and contact information) in the book for nurses and agencies to consult if they want to plan for a Third Age career and make better use of the current nursing workforce.

This is good reading for nurses who have just retired or are planning to retire in a decade or two and for nurse administrators who want to retain the wisdom and experience of their senior nurses in the workforce.
Sedation of the Ventilated Patient
By Louisa M. Golay, RN, BSN

Abstract

The quality of sedation management in mechanically ventilated patients has been a source of concern for many years. The purpose of this paper is to educate the reader about the benefits and the risks of sedative drugs. All nurses should not only have a sound knowledge of how sedatives work, but also understand the adverse effects these types of drugs can produce. The topic of whether or not standard sedation protocols should be implemented for patients on mechanical ventilation will be reviewed. Implications for nursing will be discussed and recommendations will be made summarizing evidence from documented studies.

Sedation of the Ventilated Patient

While sedative drugs provide benefits to decrease pain, agitation and anxiety levels in the critically ill patient, the adverse effects from being sedated can be detrimental. Even though sedative drugs have shown to be beneficial to critically ill patients, increased risk factors of experiencing long-term effects from these medications still exist. One identifiable life-changing adverse effect of sedative drugs is delirium. Delirium is described as “An acute, reversible organic mental syndrome with disorder of attention and cognitive function, increased or decreased psychomotor activity and disordered sleep-wake cycle” (Gardner, 2006, p. 73). The prevalence of delirium in mechanically ventilated patients is estimated between 15-40%. In this setting it contributes to increased morbidity, poorer prognosis and a mortality rate of 10-33% (Gardner, 2006). The ethical dilemma arising from this issue: are physicians allowing patients on mechanical ventilation be sedated too deeply and for too long without following set protocols, which allow the patient to wake and breathe? Without having an agreed-upon end point for sedation, nurses and physicians will likely have disparate treatment goals. This can increase the risk of iatrogenic complications and possibly impede recovery. Should healthcare facilities be required to follow standard protocols to ensure appropriate sedation levels are being achieved? Several case studies have been evaluated to determine whether or not this is a relevant issue that needs to be addressed in health care facilities nationwide.

Studies show that delirium prolongs hospital stays, increases treatment costs, and poses a threefold risk of death within six months for patients in the ICU (Landro, 2007). An example illustrating this phenomenon occurred at Vanderbilt Medical Canter in 2002. Sarah Beth Miller, 54, lay gravely ill with pneumonia and sepsis, heavily sedated on a ventilator for 10 days. She suffered several complications from her ICU experience, one of them being delirium. Miller stated “I was a highly functioning individual, but when I went back to work the first day after my hospitalization, I had to call in one of my associates and ask her what I was supposed to do” (Landro, 2007, p. D1). Miller was unable to concentrate or organize her thoughts when she returned back to work. This issue forced her to retire early from her job as a manager at BellSouth.

Even though mechanical ventilation was deemed medically necessary for Miller’s condition, she is not the only ICU patient who experienced delirium from a lengthy ICU experience. According to Dr. Ely as cited by Landro (2007), 30% to 50% of ICU patients on ventilators experience delirium after being hospitalized. Dr. Ely states “patients who are restless or aggressive are often treated too quickly with benzodiazepines, which can cause or worsen delirium” (Landro, 2007, p. D8).

Vanderbilt Medical University conducted an additional study involving 641 subjects in both the Medical ICU and Coronary ICU. The purpose was to test the validity of the Richmond Agitation Sedation Scale (RASS). It is a 10-point scale that can be rated briefly using 3 clearly defined steps that have discrete criteria for levels of sedation and agitation. A unique feature of the RASS is that it uses the duration of eye contact following verbal stimulation as the principal means of titrating sedation (Wesley, 2004). This test is able to determine if a patient is receiving too much sedation, therefore placing them at a higher risk for experiencing adverse effects of these drugs such as delirium. The results found the RASS was a sufficient and beneficial way to test if the patient was receiving too much sedation. Researchers concluded that the RASS took approximately 10 seconds to perform and provided the nurse with adequate arousal information on the patient (Wesley, 2004). Likewise, the introduction of a sedation scale and sedation protocol decreased ventilator days by 28% (from 7.4 to 5.3 days).

Preliminary evidence shows each day spent in a delirious state increases the risk of long-term cognitive impairment by 35% (Weinert, 2007). According to the Journal of Clinical Nursing, “Daily sedation interruption (DSI) has been proposed as an adjunct to titrating continuous sedative infusions to a defined sedation score or level (Bucknall & Manias, 2008, p. 1239). Currently, DSI has been
Sedation of the Ventilated Patient
By Louisa M. Golay, RN, BSN

incorporated into the Society of Critical Care Medicine sedation practice guidelines and, more recently, into the ‘ICU Care Bundles’ to prevent adverse effects. DSI has been adopted into clinical practice in Australia, USA, Europe, and Canada as well. In 2000, a randomized study was conducted involving 128 intubated patients in the medical ICU to further investigate DSI. All of the patients were receiving sedation infusions on day 2 of their ICU stay. The study found the DSI patients were extubated sooner (4.9 versus 7.3 days), discharged from the ICU faster (6.4 versus 9.9 days), and had fewer expensive neurological investigations (e.g. CT, EEG) than the conventional sedation management. Additionally, the intervention group had significantly less adverse effects than the control group. Despite daily attempts to wake the DSI group during their ICU stay, none of the patients interviewed recalled the daily process of waking (Bucknall & Manias, 2008). This review has shown that DSI has physiological benefits and less adverse effects associated with critical illness.

The benefits of sedative drugs are well understood in the intensive care unit. For example, patients on mechanical ventilation need some sort of sedative to keep them relaxed and intubated for the duration of time until they are able to breathe again on their own. The use of sedative drugs not only assists in calming patients, but also maintains their vital signs at stable levels. The prevention and treatment of pain, anxiety, agitation and delirium in the ICU are important goals to achieve; sedative drugs facilitate the prevention and treatment of these as well. Achieving a balance between sedation and analgesia, especially in critically ill patients requiring mechanical ventilation, can be challenging (Pun, 2007).

Nonpharmacologic techniques have been recommended to be used along with sedative drugs to help decrease the level of agitation as well as the amount of medication being administered. Such techniques include, but are not limited to: aromatherapy, listening to music, and back massages. These techniques have been shown to lower ICU patients’ heart rates, arterial blood pressure, anxiety levels, and reduce cardiac complications (Ashurst, 2005).

Since studies have shown delirium to be a direct cause from being sedated, hospitals are turning to new strategies to prevent delirium from happening in the first place and to reduce its duration and severity when it does occur. These strategies include: sedating patients less deeply, weaning them more quickly from ventilators, removing catheters, tubes and restraints sooner, and training nurses and other staff to frequently assess patients’ mental state (Landro, 2007).

While patients on ventilators need to be sedated to keep them comfortable, a balance between managing the pain and anxiety level of the critically ill patient and preventing further harm needs to be addressed. For sedation management practices to be optimized, nursing and medical staff need to have a comprehensive and up-to-date knowledge of the sedative drugs and narcotics they are administering. This knowledge should include drug half life, expected patient response and side effects (Meisel, 2007).

Additionally, nurses can use various methods to ensure adequate dosage control. An example of this would be using daily awakening trials involving turning the patient’s sedation off and allowing them to awaken. This “sedation vacation” protocol proves to help with less medication being given to the patient over the course of the ICU stay, thus helping to prevent drug accumulation. Likewise, this allows for sedative medication metabolism and excretion. In addition, this practice provides an opportunity for nurses to reassess a patient’s neurologic status and pain level, and may also have the benefit of allowing the patient to communicate with staff and family (Weinert, 2007). Following the ‘sedation vacation’ protocol can potentially eliminate cases of delirium all together for patients requiring mechanical ventilation and allow them to recover neurologically.

The effects of sedation on the critically ill are beneficial, yet can be harmful in the long run. Research studies confirm when standard protocols are implemented and followed correctly, the long-term effects of sedative drugs is greatly reduced. In the nursing profession, it is imperative for nurses to ensure that medications are administered correctly and in a timely manner. Nurses should follow a ‘wake-up and breathe’ protocol to monitor their patient’s overall status; especially to examine whether or not they are receiving too much sedation. The practice of setting a sedation goal score and implementing a ‘sedation vacation’ is widely recommended in the literature nationwide. A sedation goal endpoint should be established and redefined as necessary, according to the patient’s needs. Employing both of these recommendations can improve patients’ overall physiological and psychological outcomes when compared with routine sedation management.
Sedation
Continued from page 15

References


Louisa A. Golay graduated from the University of Kansas School of Nursing in 2008. She works in the Emergency Department at Olathe Medical Center and the Truman Medical Center, both in the greater Kansas City area. She is a graduate student at Washburn University working towards a Masters of Science with plans to become a Family Nurse Practitioner.
I was a young nursing student in my first rotation when a certain patient left a lasting impression on me. At the time I didn’t have any children and wasn’t yet married but the experience would provide a valuable lesson. She was a middle-aged woman, at a nursing home, who couldn’t move her legs and had limited movement of her arms. It is difficult to see someone suffer due to her limited mobility, as this was easily seen in her eyes. The little things, such as having someone brush her hair or spend time talking with her, brought her joy. Her diagnosis was Post-Polio Syndrome.

Polio may or may not cause a serious illness but can be deadly. It can cause paralysis, which will affect the muscles that help breathing. In 1916 there was a Polio epidemic that killed 6,000 people and paralyzed 27,000 more. The polio vaccine began in 1955 and decreased those numbers to 10 by 1979; no cases have occurred in the United States for 20 years. It continues to be common in some parts of the world and it can only take one case to bring it back without the vaccine (Center for Disease Control [CDC] website, n.d.).

As for the patient, she did not have the opportunity to be vaccinated. She is now suffering from the effects of a virus that is now preventable. The patient wanted to stress the importance of vaccinations and to protect the children from any serious complications related to a disease that could so easily be prevented and protect them from diseases that could permanently change their lives.

Nurse Practitioners will be faced with ethical situations when parents choose not to vaccinate children for reasons that may include misinformation. These parents cannot be forced to have their children vaccinated so how do you handle that situation when the research continues to prove the benefits? The code of ethics for nurses states that we are not to cause any harm to our patients, but yet knowing a child is not being vaccinated could cause them potential harm. It is a situation that we will all be faced with and it is important that we provide current and credible resources to our patients. Provision 2.2 in the Code of Ethics for Nurses addresses that conflicts will arise that may include conflicting expectations from the patient, and it is the responsibility of the nurse to strive to resolve those conflicts to ensure the desire of the patient for ideal care (American Nurses Association [ANA], 2001).

The CDC has guidelines for vaccines that are recommended for children and required by schools for children to attend. Yet, many parents continue to choose not to vaccinate their children for multiple reasons. Those reasons include the potential side effects, religious beliefs, and the fear of the risk of developing autism.

The autism controversy began in 1998 in a paper published by A. J. Wakefield and colleagues in The Lancet with evidence of an association between the MMR vaccine and autism (Doja & Roberts, 2006). In 2004, it was revealed that five of the patients in the original study were involved in lawsuits with vaccine manufacturers and Wakefield had received 55,000 British pounds to find evidence-linking autism to the MMR vaccine. Eventually there was a retraction of the interpretation by several of the colleagues (Doja & Roberts, 2006).

There are numerous studies with conflicting results about vaccinations and the association with autism. There have been epidemiologic studies that have found little evidence to support the hypothesis that the MMR vaccines cause autism. A retrospective study was summarized that was conducted on 537,303 children born between 1991 and 1998 in Denmark. Of those children, 440,655 were vaccinated and 96,648 were not vaccinated with MMR. It was found that there was not an increased risk of autism between the groups (Doja & Roberts, 2006). Another study that tracked mothers’ attitudes towards the MMR vaccination was done over a 10 year period, 1996-2006. In 2002, 24% of those surveyed felt that receiving the MMR vaccine was a greater risk than the diseases it protects, but this percentage decreased to 14% in 2006. There has also been a gradual increase in those who feel that the MMR vaccination is safe, from 60% in 2002 to 74% in 2006. The group of mothers who refuse to vaccinate their children remained steady throughout the 10 years at 6% (Smith, Yarwood, & Salisbury, 2007).

On the other hand, another study did reveal an association between childhood vaccinations and autism. In this study, the sample was 8-year-old children who were classified with either a diagnosis of autism or speech disorders. The study looked at multiple vaccinations and data per state. To determine if there was a link, data were collected from the diagnosis of autism or speech disorders from 2001-2007 and matched with the vaccination rates between 1995-2001 for every U.S. state. This study concluded that a 1% increase in vaccination rate was associated with a comparable 1.7% increase in autism/speech disorder in that state (DeLong, 2011). It is important to note that...
rates and proportions were documented in this study and not whether an individual child received a vaccine and then had a diagnosis of autism by the age of 8-years-old. Another important note is that speech disorders were also included in this study. The reason stated for this was that speech disorders are closely related to autism (DeLong, 2011), but can clearly be two separate disorders.

Many friends, family, and patients will look to health care professionals for advice and guidance when it comes to vaccinating their children. Using current research is essential when providing evidence-based practice. It is this information that should be given to patients and their family members so that an informed decision can be made. Research has shown that patients are influenced by physicians when it comes to information on whether to vaccinate their children or not (Smith, Ellenberg, Bell, & Rubin, 2008). This validates the importance of continued education with patients and the influential role that health care providers have on health care decisions.

Media coverage can also play a part in why an individual will choose not to vaccinate. The decision should be made behind closed doors in a private conversation between the health care provider and patient. Media coverage has been shown to have an affect on public opinion as demonstrated by a study done in Britain when the MMR vaccine was reported and shown to decrease the public opinion regarding its safety (Speers & Lewis, 2004).

It is vital for health care professionals to be able to evaluate the research and assess the credibility of the source. It is important to discuss the facts and current research when educating patients in regards to this sensitive subject. The topic needs to be covered in such a manner to not only provide the facts, but to gain the trust and rapport with the patient and family.

Vaccinations are essential in attempts to eliminate certain diseases from this world. It only takes one case to bring a disease to the forefront. Seven children in the UK, who were not vaccinated, died from rubella and measles in 2008 (Paul, 2009). While the numbers may not be large, it is significant when it can be prevented and these numbers may rise if the vaccination rates decline.

In summary, vaccinations are and probably always will be controversial. The fact remains that vaccines have diminished and even eliminated certain diseases in the U.S. It is important for health care professionals to listen to the concerns of family members and patients, and provide the facts. Ultimately, the decision is up to them but at least the facts are provided. “The benefits are clear and inarguable. The risks are miniscule. On the other hand, the risks of not vaccinating are sizable and getting larger. As more people refuse vaccinations, these diseases have increased opportunities to take hold, spread, and infect a larger proportion of the unprotected” (Paul, 2009, p. 963).

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Improving Patient Outcomes: Reducing the Risk of CAUTIs
By Dannielle Finan, RN, MSN, CNL

Introduction

Catheter associated urinary tract infections (CAUTIs) represent the largest proportion of healthcare associated infections (HAIs). CAUTIs can lead to complications including cystitis, pyelonephritis, gram-negative bacteremia, prostatitis, epididymitis, septic arthritis, endophthalmitis, urosepsis and even death (Centers for Disease Control [CDC], 2009). The Centers for Medicare and Medicaid Services (CMS) considers CAUTI a preventable complication and no longer reimburses for the extra costs of treatment (CMS, 2010). Adverse outcomes and increased costs to organizations are incentives to implement practice change to eradicate CAUTIs. There are more consequences of urinary catheterization that include patient discomfort, activity restriction, discharge delays, and the potential development of a reservoir of multi-drug-resistant organisms that can be spread to other patients. Some organizations refer to the urinary catheter as a “one-point restraint” (Saint et al., 2009).

Significance

Nursing as a profession has an interest in following the best evidence based practice to improve outcomes and decrease cost, including reducing CAUTIs. Nurses also have opportunity to conduct research, review literature, and implement evidence based practice into unit policy and practice (American Nurses Association, 2010). Recognizing that nurses manage the insertion and maintenance of urinary catheters, this article provides a resource to decrease complications related to urinary catheter insertion.

The mean cost of HAIs is $13,973 per patient. CAUTIs alone are estimated to cost $1,007 per episode (Scott, 2009). If the patient develops bacteremia secondary to CAUTI, estimates of cost increase to between $2500 and $3000 per case (IHI, 2009).

Background

HAIs also referred to as “nosocomial” or ‘hospital’ infection. The World Health Organization (WHO) defines HAI as:

an infection occurring in a patient during the process of care in a health-care facility which was not present or incubating at the time of admission. This includes infections acquired in the hospital but appearing after discharge, and also occupational infections among staff (WHO, 2008).

The most frequent adverse events in health care are HAIs; the global rates are unknown due to difficulties in data collection (WHO, 2008). In developed countries 5.1-11.6% of hospitalized patients acquire at least one of these infections (WHO, 2008). The incidence of HAI in the United States (US) is 5-6%, affecting 1.7 million patients, with urinary tract infections representing 36% of those infections. Urinary tract infections are linked to 13,088 deaths per year in the US (WHO, 2010).

Because of the prevalence of CAUTIs are believed to be reasonably preventable, it was chosen by the CMS as one of the complications for which hospitals no longer receive additional payment to compensate for the extra cost of treatment as of October 1, 2008. Because of this CMS change the incentives for organizations to implement change in order to decrease the incidence of CAUTIs are financial and improved patient outcomes (National Institutes of Health [NIH], 2009).

Urinary tract infections account for 30% of all HAIs (CDC, 2009) and nearly all urinary tract infections are caused by instrumentation of the urinary tract. Between 16-25% of hospitalized patients in the US has an indwelling urinary catheter and of these patients 21% have no medical indication for indwelling urinary catheter use (Gotelli, Carr, Epperson, Merryman, McElveen, & Bynum, 2008). Approximately 5-10% of nursing home residents are managed with chronic catheters, which often remain indwelling for years (Nicolle, 2005). Approximately one in every five patients in acute care has an indwelling catheter (NIH, 2009). In addition to the indwelling catheter, some elderly patients may have voiding managed by intermittent catheterization (Nicolle, 2005).

The CMS spent $450.5 billion providing care to 43 million Medicare beneficiaries in 2008 (CMS, 2010). CMS tracks the quality of care provided through core quality measures. CMS uses the quality measures to make information public and to link payment incentives to reporting on measures. CMS plans to pay for actual performance in the near future as opposed to fee-for-service as it has been traditional (CMS, 2010).

CMS requires reporting on 19 quality measures in the nursing home setting. These include many different aspects of patient needs, complications, and health conditions. Pertaining to this discussion are three quality measures in the nursing home (CMS,
Improving Patient Outcomes: Reducing the Risk of CAUTIs

By Dannielle Finan, RN, MSN, CNL

2010):
1. Percent of patients with a urinary tract infection
2. Percent of residents who have/had a catheter inserted and left in their bladder
3. Percent of low-risk residents who lose control of their bowels or bladder

The indwelling urinary catheter increases access of microorganisms to the bladder and inhibits complete bladder emptying. The inflated balloon which keeps the catheter in the bladder allows a small amount of urine to remain un-drained. The catheter itself is a direct route of travel for bacteria, on the inside and outside. Bacteria is more likely to become colonized on the outside of the tube from the meatus. Men are more likely to experience bacteria on the inside of the catheter and drainage system (Nicolle, 2005).

Review of Literature

A review of literature was completed for this project to extract the best evidence based practice. Research published on the topic of CAUTIs includes subtopics such as prevention, diagnosis, treatment, catheter management, cost and complications. Databases searched were CINAHL, Pub Med and Proquest. Level 1 research identified key words: urinary tract infection, UTI, catheter associated, prevention, long term care, complications, cost, indwelling urinary catheter and indication. Pub Med yielded 5,671 results with key words “urinary tract infection prevention” while Pub Med and CINAHL yielded 158 and 8 respectively in May of 2010. When “urinary tract infection” and “prevention” were searched CINAHL resulted in 397 citations, in May of 2010.

The IHI (Institute of Healthcare Improvement) has released recommendations for CAUTI prevention in the form of a how-to guide. This guide states these elements will decrease episodes of CAUTI:
1. Avoid unnecessary urinary catheters.
2. Insert urinary catheters using aseptic technique.
3. Maintain urinary catheters based on recommended guide lines.
4. Review urinary catheter necessity daily and remove promptly.

The Bladder Bundle initiated by the Michigan Health and Hospital Association (MHA) Keystone HAI listed five key practices (Saint et al., 2009).
1. Nurse-initiated urinary catheter discontinuation protocol.
2. Urinary catheter reminders and removal prompts.
3. Alternatives to indwelling urinary catheterization.
5. Insertion care and maintenance.

Summary

Of the literature reviewed many themes emerged. Research supports that urinary tract infections can be reduced through the implementation of best practice through reminder systems (Meddings, Rogers, Macy & Saint, 2010). Some of the strategies are (a) use of a nurse driven protocol for indwelling urinary catheter insertion and continuation, (b) catheter management, and (c) use of bladder scanners. These protocols can be bundled together for ease of use and understandability. As stated by the CDC most all urinary tract infections can be linked to instrumentation; therefore decreased use of instrumentation will decrease episodes of urinary tract infections in all patient care settings.

Recommendations

The recommendations for the best patient outcomes based on a synthesis of the literature are to: after collaborating with providers within the organization, implement a nurse driven protocol following a simple algorithm for discontinuation of IUCs, update all policy and procedures for the organization affecting the use and management of IUCs with the most current best practice (table 1, page 22), and implement reminders in the organization’s system to discontinue IUC promptly. After implementing the best evidence practice, collect data to assess the positive changes in patient outcomes and financial gains.

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Centers for Medicare and Medicaid
Improving Patient Outcomes: Reducing the Risk of CAUTIs

By Dannielle Finan, RN, MSN, CNL


Dannielle Finan graduated from Washburn University in 2005 and earned her Masters of Science in Nursing in May 2011. Her career has taken her into critical care nursing with a passion for end of life care and organ donation.

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Improving Patient Outcomes: Reducing the Risk of CAUTIs
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Table 1
Sample: Policy for Prevention and Control of Urinary Tract Infection

PREVENTION AND CONTROL OF URINARY TRACT INFECTION

1. PURPOSE: To establish policy for the prevention and control of urinary catheter associated urinary tract infection in the Community Living Centers

2. POLICY: The Community Living Centers will implement policies and procedures to prevent and control urinary tract infections among residents with foley catheter insertion.

3. URINARY CATHETERIZATION PROCEDURE:
   a. Obtain an urethral catheterization order from a physician with one or more of the following indications:
      (1) An acute urinary retention or bladder outlet obstruction.
      (2) A need for strict measurement of output in critically ill residents.
      (3) A perioperative use for some surgical procedures.
      (4) A healing of open sacral or perineal wounds in incontinent residents.
      (5) A resident requires prolonged immobilization.
      (6) An improvement to end of life care or a resident request.
   b. Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site.
   c. Personnel must be adequately trained and proven proficient before performing urethral catheterization and catheter care related procedures.
   d. Insert urinary catheters using aseptic technique and sterile equipment. See procedure titled Catheter insertion, indwelling.
      (1) Using sterile gloves, drape, sponges, an appropriate antiseptic or sterile solution for periurethral cleaning, and a single-use packet of lubricant jelly for insertion.
   e. Properly secure indwelling catheter after insertion to prevent movement and urethral traction.
   f. Consider using the smallest bore catheter possible, consistent with good drainage, to minimize bladder neck and urethral trauma.
   g. Use bladder scanner to assess urine volume in residents who have suspected urinary retention before insertion of an indwelling urethral catheter.

4. URINARY CATHETER MANAGEMENT:
   A. Maintenance:
      1. Following aseptic insertion of the urinary catheter, maintain a closed drainage system.
         If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment.
      2. Maintain unobstructed urine flow.
         a. Keep the catheter and collecting tube free from kinking.
         b. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.
         c. Empty the collecting bag regularly using a separate, clean collecting container for each resident; avoid splashing, and prevent contact of the drainage spigot with the non-sterile collecting container.
   3. Use standard precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system.
   4. Nursing staff at CLC will keep a log of daily catheter need assessment and document reason for continued use of indwelling urinary catheter. The provider will review the log in collaboration with nursing staff to assess possible discontinuation of indwelling urinary catheter.
   5. Indwelling catheters should be removed as soon as possible. Alternative methods of urinary drainage (i.e., condom catheter, intermittent catheterization) should be considered whenever possible.
   6. If indwelling catheter is deemed necessary for a veteran. The provider should enter a stop date in CPRS.
   7. All indwelling catheters will be attached to closed drainage systems and sealed at the catheter-drainage bag junction (pre-attached by manufacturer). The seal must not be broken for collecting specimens or for irrigating. If the...
connection becomes accidentally separated and contaminated the drainage bag and tubing must be replaced.

8. To maintain an adequate flow of urine, the resident will be monitored for fluid balance.

9. Urine specimens for culture, glucose/acetone determinations, etc., will be obtained only by aseptic needle aspiration from the designated port between the catheter and the tubing.

10. Irrigation of catheters will be done only when obstruction is suspected using aseptic technique. Obstruction is indicated by decreased urine output and sensation of full bladder. See policy titled Catheter Irrigation.

11. There is no need to routinely change the systems (i.e., the catheter, or drainage system) as long as urine is flowing freely. Residents, whose catheters will be in place for several weeks, or indefinitely, need the system changed periodically, particularly when concretions or sediments (crystalline deposits) are noted in the catheter, or tubing or when infection, malfunction, or obstruction occurs.

12. Continuous bladder irrigation by way of a closed three way catheter system, although effective following urological surgery, is not recommended for other residents because of the extra expense and nursing attention required for adequate function.

13. Routine hygiene, cleansing of the meatal surface during bathing, will be performed daily.

B. **Documentation:**

1. Nursing staff at CLC will keep a log of daily catheter need assessment and document reason for continued use of indwelling urinary catheter. The provider will review the log in collaboration with nursing staff to assess possible discontinuation of indwelling urinary catheter.

2. Nursing staff will document insertion indication, date and time of insertion, individual inserting the catheter, daily catheter hygiene and date/time of removal.

C. **Specimen collection:**

1. Obtain urine samples aseptically.
   a. If a small volume of fresh urine is needed, aspirate the urine from the needleless sampling port with a sterile syringe/cannula adapter after cleansing the port with disinfectant.
   b. Obtain large volumes of urine for special analyses (not culture) aseptically from the drainage bag.

D. **Condom Catheter Drainage:**

1. This form of drainage is of particular value for the comatose or incontinent male resident who cannot otherwise completely empty his bladder.

2. The condom catheter must be removed and changed at daily intervals to prevent skin maceration/urine volume in residents who have suspected urinary retention before insertion of an indwelling urethral catheter.

3. Urine obtained from condom catheters is not reliable for culture purposes because of contamination. Either an assisted clean-catch voided specimen should be obtained or the specimen should be obtained by single catheterization.

E. **Single Catheterization:**

1. Urethral catheterization should be avoided as a means to collect routine urine samples, but may be necessary when a resident is unable to assist with urine collection or when a medical condition prohibits a veteran from doing so.

2. Prior to the use of single or straight catheterization to relieve urinary retention, a bladder scan of the bladder should be done and indicate a urine level greater than 200mls.

3. Some residents with conditions requiring long term urinary drainage may perform intermittent self catheterization as a means of decreasing duration of indwelling catheters and thereby decreasing the frequency of infection. Clean technique, rather than sterile, is appropriate in the CLC for residents performing their own intermittent catheterization.

Avoiding the indwelling catheter should be a priority to prevent infection.

5. **RESPONSIBILITY:** All Nurse Managers of CLC employees who examine, diagnose, and treat residents or who perform procedures described in this policy are responsible for ensuring compliance and that employees receive appropriate training from the designated Clinical Nurse Leaders and Coordinators.

6. **REFERENCES:**

