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CONTACT INFORMATION

1109 SW Topeka Blvd.
Topeka, KS 66612-1602
785-233-8638 x300
Fax 785-233-5222
ksna@ksnurses.com
www.ksnurses.com

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CO-EDITORS: Tona Leiker, PhD, APRN-CNS, CNE, and Debra Pile, DNP, RN

REVIEWERS: Penny Chura, PhD, RN; Kathleen Harr, PhD, RN; Janice Jones, MN, APRN; Deborah Lang, BSN, RN

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MISSION: The KSNA promotes professional nursing, provides a unified voice for nursing in Kansas and advocates for the health and well-being of all people. It was established February 1912 at Wichita, Kansas.

IN THIS ISSUE

Upcoming KSNA Board Meetings

Monday, February 20
Conference Call, 6 p.m.

Dues Tax Deduction

The Omnibus Budget Reconciliation Act of 1993 requires the Kansas State Nurses Association to notify members that the percentage of Kansas State Nurses Association/American Nurses Association (ANA) dues, which is allocated to lobbying expenses, is not deductible as an ordinary and necessary business expense for federal income tax purposes.

The Kansas State Nurses Association estimates that the nondeductible portion of 2016 Missouri Nurses Association/ANA dues which will be allocatable to lobbying expense is 16.69 percent.

Director's Message

By Linda Becker

Hello Kansas State Nurses Association! As many of you know there have been changes within your KSNA and I am one of them.

My name is Linda Becker and I have been a long standing member of KSNA since I started my profession. In December I celebrated 30 wonderful years as a nurse and 20 years as nurse practitioner.

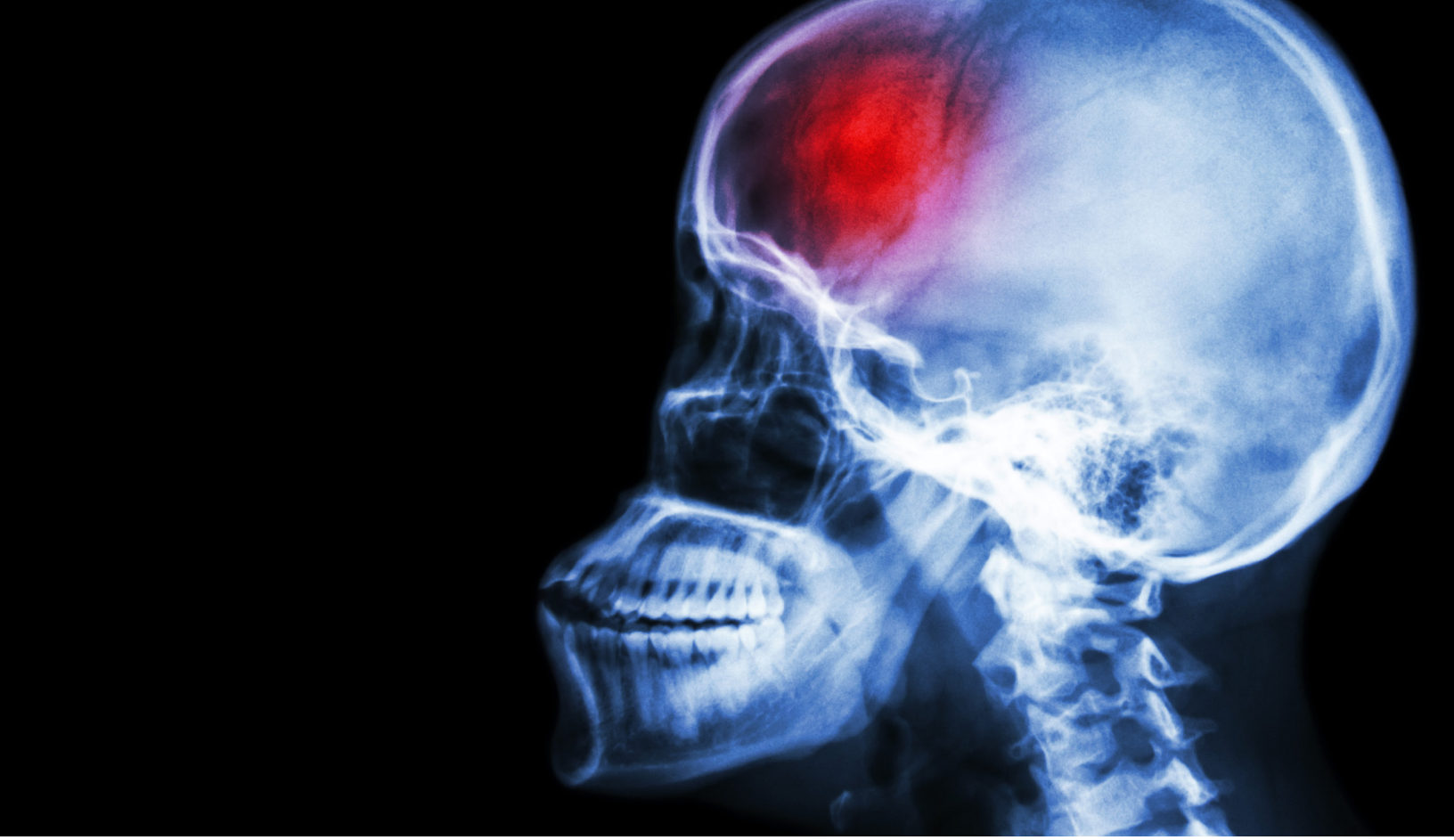
I am excited to be part of the change that KSNA is undergoing. My role as state director encompasses membership and advocacy. While we realize that change is never easy, it is necessary in our evolving world.

Our vision for KSNA is for all members to feel part of a team and create a partnership to take this wonderful organization to new levels of success. There are many members who have worked hard within KSNA to build a strong organization and to those we say a big "thank you." We need to sustain that hard work by attracting new members.

There are many plans and ideas underway to reach out to potential new members. We will be using technology such as a blog where members can send requests, thoughts or recommendations to me personally as your state representative. We will continue our Kansas Nurse as the voice of our organization and I will be making personal visits to each region, nursing schools and area hospitals.

I hope to be available to each and every one of you as your state director. As our vision states " The Voice and Vision of Nurses in Kansas" must be heard.

It truly is A New Day At KSNA!



Impacting Stroke in Kansas: Opportunities for Nursing in Early Recognition and Acute Treatment

By Wendy Dusenbury DNP, APRN, FNP-BC, CNRN, ANVP-BC

Dusenbury

Every 40 seconds someone you know experiences a stroke in the United States (Mozaffarian et al., 2016). Stroke is ranked fifth among all causes of death and is the leading cause of preventable adult disability. An estimated 795,000 Americans experience a new or recurrent stroke each year and of these, 87% are ischemic stroke, 10% are intracerebral hemorrhages, and 3% are subarachnoid hemorrhages (Mozaffarian et al., 2016). The rate of stroke deaths outside of an acute care hospital has been estimated as high as 59% (Mozaffarian et al., 2016), indicating that community education should be an important cornerstone in addressing the recognition of stroke symptoms, the need to call 911, and also identifying stoke as a significant health problem among the population. Similarly, education of patients, families, nurses, and all health care providers is pivotal.

Stroke resulted in an overall cost of $33 billion in 2011, with direct medical costs at $17.2 billion (hospital outpatient or office provider visits, hospital inpatient stays, ED visits, medications, and home health care) and the mean expense per patient for direct care was $4,830 (Mozaffarian et al., 2016). Costs are expected to triple by 2030, and adults aged 65 to 79 are expected to bear the burden of increased cost of care. Additionally, women's lifetime risk of stroke is higher than men (Mozaffarian et al., 2016). Collectively, these data illustrate the importance of early recognition of stroke, an area of critical importance in improving stroke outcomes.

The Kansas stroke rate has been consistently higher than national averages (2009-2013) (Annual Summary of Vital Statistics, 2014, 2015.) Data from 2013 and 2014 ranks stroke as the 5th leading cause of death among all ages of Kansans (Annual Summary of Vital Statistics, 2014, 2015). In 2013, there were 1,306 stroke deaths in Kansas, with the highest rates of death occurring in the Northcentral and Southeast regions of the state, with age-adjusted death rates of 43.7 and 42.6 per 100,000 population, respectively. In contrast, the Northwest region had the lowest age-adjusted stroke rate at 33.4 per 100,000 population. Consistent with national patterns, women have higher rates of stroke deaths in Kansas. Overall stroke death rates were higher in non-Hispanic Whites, while non-Hispanic Blacks had higher age-adjusted stroke death rates (Annual Summary of Vital Statistics, 2014, 2015). Of concern, more than half of Kansans with stroke die before arriving at an acute stroke center (Kansas Department of Health and Environment Kansas Heart Disease and Stroke Prevention Program, 2010).

Systems of Stroke Care in Kansas

Stroke systems of care are defined as organized care structures across

the state that will ensure proper treatment of stroke patients and result in a reduction of death and disability. This structure includes multiple levels of care for the stroke patient including: prehospital care and triage, various levels of stroke centers, telemedicine, advanced medical, endovascular and surgical interventions, and comprehensive rehabilitation programs. A policy statement by the American Heart Association/American Stroke Association states that a fully functional stroke system of care capable of reducing stroke related deaths by 2-3% annually would reduce 20,000 deaths in this country alone and approximately 400,000 worldwide (Higashida et al., 2013). Such an organized care system would also reduce post-stroke disability, thereby improving quality of life, while reducing the financial burden of stroke.

The treatment of stroke is very time dependent. The time from the onset of symptoms to the presentation to the emergency department is the greatest source of delay and is most commonly the reason for ineligibility for reperfusion therapy (Higashida et al., 2013). The biggest component in this delay is lack of patient and public awareness of the signs and symptoms of stroke, and an understanding of the need to urgently seek treatment (Higashida et al., 2013). There are still a large portion of stroke patients within Kansas and the United States that arrive via private vehicle, causing a substantial delay in patient treatment and ultimately effecting patient outcomes. Multiple studies have demonstrated that prehospital notification by EMS can significantly reduce evaluation and treatment times (Higashida et al., 2013).

Stroke Centers

Levels of hospital care defined by the Brain Attack Coalition and the American Heart (AHA) /American Stroke Association (ASA) include: Acute Stroke Ready Hospitals (ASRH), Primary Stroke Centers (PSC), and Comprehensive Stroke Centers (CSC). Stroke hospital designation is available through several certifying bodies such as The Joint Commission (TJC), Dete Norske Veritas (DNV), and Healthcare Facilities Accreditation Program (HFAP), although not each of these certifying agencies is currently prepared to certify all of these levels of stroke services. Hospital designations for stroke care are important because this points out stroke service capabilities, with laws in some states requiring ambulance transport to specific levels of stroke care. For example, several states now mandate bypassing hospitals without stroke center certification by one of the agencies listed above, in an effort to ensure delivery of the best possible stroke care. However, Kansas currently lacks ambulance transport legislation to stroke center hospitals; therefore, hospitals unprepared to rapidly diagnose and treat stroke patients may receive these highly vulnerable patients regardless of stroke care readiness.

Acute Stroke Ready Hospitals (ASRH) are either recognized by a certifying body or attest with KISS (Kansas Initiative for Stroke Survival) to their preparedness, meaning that they are capable of performing a rapid noncontrast computed tomography (CT) scan and diagnosing an acute stroke, along with the ability to administer intravenous alteplase thrombolysis (IVtPA). These hospitals may likely be the first stop for stroke care, particularly in rural areas of Kansas, prior to transfer to a primary or comprehensive stroke center.

There are currently 11 PSCs in Kansas. Similar to ASRHs, PSCs should be capable of providing IVtPA to acute ischemic stroke patients, as well as managing all core measures for patients admitted within their system, such as anticoagulation for patients with atrial fibrillation or other stroke cardioembolic mechanisms, venous thromboembolism prophylaxis, stroke education, statin medications and antiplatelets for ischemic stroke, and TJC-specific recommendations such as performing swallow screens on all admitted patients. The concept of PSCs was first proposed by the Brain Attack Coalition in 2000, and The Joint Commission began providing certification in 2004 (Jauch et al., 2013). Similar to ASRHs, PSCs should be prepared to transfer complex stroke patients to CSCs as rapidly as possible, however, time to transfer (i.e. time from diagnosis to "out the door" on route to a CSC) has yet to be quantified.

In 2012, TJC began certifying CSCs with the goal of 24 hour state of the science care delivery for a full spectrum of neurovascular diseases, including the ability to perform endovascular thrombectomy and aneurysm coiling/occlusion, as well as designation of a dedicated neuro-critical care unit (Jauch et al., 2013). There are currently two CSCs in Kansas. The University of Kansas in Kansas City, certified in 2014, and most recently, Via Christi Health-St. Francis Campus in Wichita, certified in early 2016. Patients with ischemic stroke demonstrating emergent large artery vascular occlusion (ELVO) on CT angiography (CTA) or clinically suspicious for ELVO, as well as those with aneurysmal subarachnoid hemorrhage (aSAH) or vascular malformation associated intracerebral hemorrhage should be emergently transported to a CSC for management per national standard of care (Jauch et al., 2013).

Nursing Role in Stroke Care

Nurses are uniquely positioned to be among the first health care providers to recognize stroke manifestations, and early recognition of stroke is well recognized as essential to decrease stroke morbidity and mortality. In the acute care setting, the nurse is often the person performing the initial assessment during triage in the emergency department, as well as assessing sudden onset neurologic dysfunction in patients admitted for other diagnoses. Standardized assessment using the National Institutes of Health Stroke Scale (NIHSS) (Table 1) is an important aspect of the stroke assessment and is required for stroke certified hospitals. The NIHSS gauges the degree of neurological deficit, pinpoints areas of potential vessel occlusion, and allows for repeated standardized assessments for comparison over time (Jauch et al., 2013). The NIHSS is the only valid and reliable assessment of neurologic dysfunction associated with stroke, unlike the Glasgow Coma Scale (GCS), which is commonly used but ignores stroke deficits in favor of the "best response" (Nye et al., 2012). In fact, use of the NIHSS should be mandated in all hospitals admitting acute stroke patients throughout the state to ensure use of a common language describing neurologic disability.

Along with early recognition of stroke, prompt treatment is essential. Guidelines specify that door to physician should occur in less than 10 minutes, with door to stroke specialist arrival occurring in less than 15 minutes from the time the patient arrived in the Emergency Department (ED). Door to completion of the NIHSS should occur

in less than 15 minutes, door to CT scan initiation must be less than 25 minutes with door to CT scan interpretation less than 45 minutes, and door to needle bolus of IVtPA must be less than 60 minutes. While these times may seem aggressive, the current focus is on shortening times even further to 30-45 minutes for door to IVtPA bolus in acute ischemic stroke (Jauch et al., 2013). As the most prevalent provider and largely the personnel that manage hospital systems, nurses are critically positioned to play a major role in reducing door to needle times.

Stroke Education

Community Education

Public awareness of the recognition of stroke signs and symptoms is fundamental to delivery of acute stroke care. However, findings continue to reveal that the public knowledge (Kleindorfer et al., 2009), as well as stroke patient/family knowledge of stroke signs and symptoms is poor, and as previously discussed, many patients arrive to the ED by private vehicle, further delaying treatment and potentially worsening outcomes (Jauch et al., 2013). Every minute that treatment is delayed in acute ischemic stroke, millions of neurons die (Saver, 2006), therefore, methods to increase bystander, patient and family knowledge of stroke are essential. Recently, a pilot study of test-enhanced learning (TEL) demonstrated that patients and family members retained stroke education better when told that they had to pass a 4-question written exam on essential stroke knowledge (Johnson, Urrutia, & Alexandrov, 2016).

A cluster randomized trial of TEL is currently underway to determine the efficacy of this intervention in improving patient/family knowledge of stroke signs and symptoms, risk factors, medications to prevent stroke, and rapid access to care (www.teststroke.com).

Table. 1 Resources for Nurses and Health Care Providers

Provider Specific Resources	
NIHSS Certification	https://learn.heart.org/nihss.aspx
CDC	http://www.cdc.gov/stroke/materials_for_professionals.htm
American Heart Association	http://www.heart.org/HEARTORG/
NET SMART	http://www.learnstroke.com/
University of Kansas-Comprehensive Stroke Center	http://www.kumed.com/neurosciences/stroke-center
Via Christi Health-St. Francis Comprehensive Stroke Center	https://www.viachristi.org/locations/hospitals/via-christi-hospital-st-francis/neurology/stroke
Kansas Initiative for Stroke Survival	www.kissnetwork.us
Kansas Heart and Stroke Collaborative	http://www.kumed.com/about-us/community-outreach/heart-stroke-collaborative
Bi-State Stroke Consortium	http://www.heart.org/HEARTORG/Affiliate/Bi-State-Stroke-Consortium_UCM_304032_Article.jsp - .Vu7rNxjX5Bw
Patient Education Resources	
Centers for Disease Control	http://www.cdc.gov/stroke/materials_for_patients.htm
American Heart Association	http://www.heart.org/HEARTORG/
Agency for Healthcare Research and Quality	http://www.ahrq.gov/
American Stroke Association	http://www.strokeassociation.org/STROKEORG/AboutStroke/Lets-Talk-About-Stroke-Patient-Information-Sheets_UCM_310731_Article.jsp - .Vu9UIT_X5Bw
Targeted Education in Stroke Trial (TEST Stroke)	www.teststroke.com

Nursing and Healthcare Professionals

Education of healthcare professionals (HCP) regarding recognition and treatment of stroke is vitally important to improving stroke care across Kansas. First responders, nurses, and health care providers must be educated in rapid recognition and implementation of protocols to diagnose, provide treatment with IVtPA, and as necessary transfer patients to appropriate PSCs or CSCs.

Statewide Organizations

The American Heart Kansas Chapter provides an incredible amount of educational resources about stoke and cardiovascular disease for healthcare providers, patients, and families.

The Kansas Initiative for Stroke Survival (KISS) is an organization made up of various stroke providers across the state, working to improve stroke care in Kansas by providing educational opportunities to providers of all levels.

The Kansas Heart and Stroke Collaborative (KHSC) is a grant-funded program through the University of Kansas Hospital with the goal to provide high quality care for rural Kansans and to reduce the healthcare costs associated with cardiovascular disease and stroke (University of Kansas Hospital, n.d.).

Summary

Stroke places significant burden on individual as well as state and national resources and finances. Great strides have been made to improve stroke care in Kansas, however, much work is left to be done particularly in the area of rapid diagnosis, treatment and transfer. Nurses are well positioned to champion evidence-based acute stroke care and must play a leading role in improving acute stroke services and systems of care in an effort to improve acute stroke outcomes.

Dr. Wendy Dusenbury is a board certified as a family nurse practitioner and an advanced neurovascular practitioner, an Assistant Professor at Wichita State University, and APRN on the Mobile Stroke Unit for the University of Tennessee Health Sciences in Memphis Tennessee.

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Family Presence During Resuscitation

By Kendra Jermark and Libby Rosen, PhD, BSN

Jermark

Rosen

Family presence during resuscitation (FPDR) poses many benefits, not only to the family and patient, but also to the healthcare team. Statistical studies have shown that family members expressed appreciation about being present with their loved one, felt reassured that the healthcare team "did everything possible," and believed they had a role in providing pertinent medical information to the healthcare team when the patient was unable to do so themselves. As FPDR has become more common, some concerns have been raised including the potential for increased feelings of pressure on the healthcare team, distractions from the family that could interfere with the process, psychological trauma on the witnesses, and possible lawsuits towards the healthcare team (Hardin-Fanning & Yoder, 2014, p. 4). The beneficial practice of FPDR is growing, therefore, creating a need for policy development and education for all health professionals.

In 2001, the Institute of Medicine recommended that healthcare should strive to be more family-centered, leading to the controversy of about FPDR (Ganz & Yoffe, 2012). Family presence during resuscitation is defined as "the attendance of one or more family members in a

location that affords visual or physical contact with a patient during CPR" (Dwyer & Friel, 2016, p. 274). The American College of Critical Care Medicine, American Heart Association, American Association of Critical Care nurses, the European Society of Cardiology Council of Cardiovascular Nursing and Allied Professional, and the European Federation of Critical Care Nursing Associations all support FPDR (Carroll, 2014). Only five percent of emergency departments have policies in place about FPDR (Hardin-Fanning & Yoder, 2014).

Patients and their families need to be aware of the option of FPDR. A holistic approach to patient care is to assess if FPDR is something the patient and family desires. Healthcare professionals can be paternalistic without being aware they are doing so. Assumptions are often made regarding the healthcare of a patient due to the background of medical knowledge that healthcare professionals possess. According to Doolin and colleagues (2011), healthcare providers expressed the viewpoint that allowing FPDR was ethically the right thing to do in what could be the last moments of that patient's life. Family presence during resuscitation allows for "closure of a life shared together" when CPR efforts are not successful (Leske, McAndrew, & Brasel, 2013, p. 78).

Families conveyed feelings of comfort when allowed to be with their loved one during CPR and their presence gave them the opportunity to say goodbye. If FPDR were not an option for them, it would have been a lost opportunity (Doolin et al., 2011). Studies have shown that unconscious patients can hear their relatives caring voices near them during their code (Leung & Chow, 2012). Doolin et al. (2011) described one patient's perspective after experiencing FPDR, stating that he could feel his wife's presence at his bedside and this "encouraged him to fight for survival" (p.11).

Sak-Dankosky and colleagues (2013) conducted a study on how nurses and physicians view FPDR. The most frequently reported benefit was giving the witnessing family members the opportunity to see that everything was done for that patient (Sak-Dankosky et al. 2013). In an evaluation after witnessing FPDR, families found it comforting to see the healthcare team work together and described the effort as an "all hands on deck" approach (Leske et al., 2013, p. 80).

Family witnessed resuscitation also poses the benefit of allowing the family to advocate for the patient regarding pertinent medical information, and to receive frequent updates on the patient's condition (Sak-Dankosky et al., 2013). Leske et al., (2013) reported the family felt reassured that they were there to make sure the staff was well aware of every essential medical detail such as health history, current medications, and allergies. Healthcare providers identified that FPDR would help the family understand and comprehend their family member's condition (Doolin et al., 2011). When FPDR was implemented in the pediatric intensive care setting, parents reported that it allowed them to make decisions and advocate for their child (Smith & Carew-Lyons, 2014). Healthcare professionals in support of FPDR believe that allowing family to be present during a code can help start the grieving process for the family (Dwyer & Friel, 2016).
One objection to FPDR is the feelings of increased pressure on staff (Carroll, 2014). Results showed family presence did not inhibit medical residents' abilities to make decisions, but promoted increased team collaboration (Doolin et al., 2011). Leske et al. (2013) studied the provider's interactions during FPDR and concluded that communication was not affected.

Another objection to FPDR is that the family could lose control and inhibit CPR efforts by distracting the team (Clark, Guzzetta, & O'Connell, 2013). Dwyer and Friel (2016) reported no significant disruptions or distractions by family members during FPDR.

Concerns about displayed aggression by witnesses was analyzed and only one percent of the 570 participants showed aggression or were in conflict with staff during the code (Jabre, Belpomme, Azoulay, Jacob, Bertrand, Lapostolle, & Turi, 2013). Leske et al. (2013) found that family did not want to take the staff away from their loved one and distract them during the code.

When healthcare employees were asked about their fears related to FPDR, they mentioned the experience causing emotional and psychological trauma to the witnesses (Clark et al., 2013). Jabre at al. (2013) examined if FPDR increased the witnesses' incidences of PTSD, depression, and anxiety, finding the control group (non-FPDR), had greater symptoms of PTSD, anxiety, and depression than the group who did experience the code.

Clark et al. (2013) shared that healthcare staff also feared FPDR would increase the number of lawsuits. Jabre et al. (2013), found that during two years of FPDR, out of 570 participants, there were no legal claims against the medical team. The observers get to view "the exhaustive process that transpired to save the patient's life and thus diminishes potential lawsuits" (Parial, Torres, & Macindo, 2016, p. 220).

Lack of policies about FPDR in healthcare settings is an issue. Doolin et al. (2011) suggested that upon admission, if able, the patient would receive information about the facility's policy on FPDR, and if interested, receive a handbook on FPDR. A trained family support facilitator (designated nursing staff member, social worker, or a chaplin) should be available to stay with the family if a code should occur (Doolin et al., 2011). This person's job is to prepare patients and family for what to expect in the code setting upon entering (Jabre et al., 2013). The family support person should continually assess for escalating behaviors and escort the relative to a designated debriefing area if needed (Jabre et al., 2013). Doolin et al. (2011) suggested that participation be limited to immediate family members and possibly to limit how many can observe, as space can be an issue during codes. To accommodate FPDR and space issues it was suggested to increase the room size in critical care settings, where codes most likely occur (Leung & Chow, 2012). For these reasons it is vital that policies be established.

By increasing the research efforts concerning FPDR, new findings may be discovered to help develop and write policies. Certain healthcare facilities have yet to implement FPDR because it remains a debatable practice (Parial at al., 2016). This lack of acceptance inhibits FPDR from becoming standard practice.

The decrease in acceptance by healthcare staff may be due to the lack of knowledge of FPDR's benefits. More education needs to be available to healthcare staff, to increase acceptance and implementation of FPDR (Hardin-Fanning & Yoder, 2014). Nursing professionals need to stay up-to-date regarding facility policies,

evidence based practices, and national guidelines regarding FPDR. Nurses should be aware of their personal opinions concerning FPDR and not let it affect patient care. Approaching the situation with a nonjudgmental attitude, respecting the patient's autonomy, and assessing the family's choices about FPDR can ensure that the practice of FPDR is fulfilled.

Family presence during resuscitation provides many benefits such as: comforting the patient and family, allowing the family to advocate for their loved one, providing important information, helping the family grasp the reality of the situation, providing reassurance that everything was done to help the patient, as well as facilitating the grieving process. Healthcare staff has voiced concerns regarding FPDR such as: increased stress on the code team, unnecessary distractions, and increased trauma to the witnessing family, potential legal concerns. Every healthcare setting should establish and implement policies regarding FPDR, and educate staff on the benefits and what to do if working in a code situation with family present. The benefits of FPDR far outweigh its concerns and should be the policy at all healthcare institutions.

Kendra Jermark will graduate from Baker University School of Nursing, Topeka, in May 2017. Originally from Glen Elder Kansas, Kendra enjoys spending time with her family and friends. Kendra has worked as a CNA for four years in various settings of nursing including: nursing home care, home health, acute hospital settings, obstetrics, and neonatal intensive care. After completing her bachelor's degree, Kendra hopes to further her education by attaining either an APRN or CRNA degree.

Libby Rosen has been a nurse for 42 years in Topeka, Kansas. She received her Nursing diploma from Stormont-Vail School of Nursing in 1974, her BSN from Washburn University in 1994, and her PhD from the University of Kansas in 2009. She is a Professor of Nursing at Baker University with her clinical work focusing on maternal-child care and working with grieving families.

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Legislative Update

By Carol Moore, legislative committee chairperson

The Kansas State Nurses Association (KSNA) was in attendance at the Special Committee on Organizations of Public Health Boards hearings on Dec 6 and 14, 2016. The impetus for these hearing was based on the Alvarez and Marsal Efficiency Study, realizing cost and personnel savings by combining health related boards. What began as a proposal to merge the Kansas State Board of Nursing and the Kansas Board of Healing Arts expanded to include other public health boards, all of whom presented testimony in opposition.

The first day (Dec 6th) was designated for public health boards to present testimony. The KSBN executive director Mary Blubaugh presented convincing factual evidence that clearly demonstrated efficiencies already in place. It was very obvious that the Board of Healing Arts was not close to matching those efficiencies.

The second day (Dec 14th) was set aside for stakeholders to present oral or written testimony which KSNA did. The conference room was filled to capacity with nurses in the majority and this was noted by the chairman of the committee.

After a lunch break the committee reconvened and within 30 minutes, determined efforts to combine boards would not provide

the efficiencies sought. Based on the governor's State of the State address, this issue is likely to surface again.

Bills that are being monitored for this session are the following, most in the House Health and Services Committee.

SB38 & HB 2064
Establishing the KanCare Bridge to a healthy Kansas program (expanding Medicaid) KSNA will present written testimony in support.

HB 2076
This is the SAFE bill, the seat belt education bill that expands the SAFE (Seat Belts are For Everyone). This is a program that is presented in Kansas high schools. Those schools that participate have seen a dramatic increase in seat belt usage by teen drivers. In 2015 this bill (SB 274) passed the Senate 33-2. In 2016 it went to the House where it had support but not afforded a vote, hence, the reintroduction of the SAFE bill in 2017. KSNA is demonstrating support for this bill by being a sponsor of the testimony.

HB 2008
Promoting seat belts on school buses. The information that I have read regarding seat belts usage on buses is mixed pro/con. Comments from KSNA membership are welcome.

HB 2022
"Kansas Right to Try" provides the opportunity for an individual to try treatment/medication that has not been through the approval process. The premise is the length of time it takes for approval, the individual will have expired. I encourage you to read this bill.

HB 2120
Death with Dignity Act is another bill worth reading all 10 pages. There are a number of qualifications and stipulations in place but the point of this bill is found in Sec. 3. (a) "An adult who is capable, is a resident of Kansas and has been determined by such adult's attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed such adult's wish to die, may make a written request for medication for the purpose of ending such adult's life in a humane and dignified manner in accordance with the provisions of the Kansas death with dignity act." This will be very controversial and we should remember that ANA states that nurses should not participate in the act of ending another person's life.

Nurses on Boards in Kansas: A Targeted Board Descriptive Study

By Heather V. Nelson-Brantley, PhD, RN, CCRN-K and Cynthia S. Teel, PhD, RN, FAAN

The Institute of Medicine (IOM, 2011) calls for nurses to serve as full partners, along with other professionals, in redesigning health care in the United States. Leading the transformation of health care will require nurses to expand their roles from caregiving and care management to more prominent contributions as decision makers on healthcare boards of directors (BODs) (Curran & Totten, 2010; Hassmiller & Combes, 2012; IOM, 2011). Nurses possess knowledge, skills, and professional values integral to the success of BODs, including: (a) credibility with policymakers, employees, and health administrators, (b) sustained public trust, (c) assessment skills to triage problems, (d) effective retention strategies, and (e) an on-the-ground sense of community health needs (Curran & Totten, 2010). Comprehensive data regarding the number of nurses serving as voting members of hospital, health system, health education, and

Nelson-Brantley

Teel

community health-related boards are unavailable. Studies suggest, however, that despite being well-qualified, nurses comprise a very small percentage of the members on BODs, ranging from 2% (Prybil, 2009) to 6% (Prybil, Dreher, & Curran, 2014) nationally.

The Future of Nursing: Campaign for Action (CFA, 2013), a collaborative effort of the Robert Wood Johnson Foundation (RWJF) and AARP through the Center to Champion Nursing in America (CCNA), recommends that, "Hospitals and policy organizations seeking to improve the quality and safety of care should appoint at least one nurse to their governing boards" (p. 1). The IOM (2011) similarly recommends that leadership positions are available to and filled by nurses. The Nurses on Boards Coalition (NOBC), a national coalition of 21 major professional organizations, was formed in 2014 to work on increasing nursing's presence on corporate and non-profit health-related BODs throughout the United States. The goal of the NOBC is to place 10,000 nurses on governing boards by 2020 (Boyle, 2014). Kansas has 128 community hospitals, 84 critical access hospitals, and nine 'other' types of hospitals (Kansas Hospital Association, March 20, 2015). While information regarding the number of Kansas hospitals is readily available, little information is available regarding the number of nurses currently serving on hospital and other health-related BODs in the state. A first step in realizing nursing leadership from the bedside to the boardroom (IOM, 2011) requires describing the number of nurses currently serving on boards as well as the geographic areas where nurses serve in Kansas. Baseline data are needed to understand more about current participation and to guide efforts for increasing nursing representation on boards of directors.

Wisconsin investigators recently collected data about nurse participation on health-related boards. Rather than sampling all nurses, the Wisconsin group targeted specific boards and organizations to determine the presence of nurses on BODs in the state. The study sample included schools of nursing boards, hospital and hospital system boards, and non-profit systems (WCNb, 2014). Study participants included deans of Wisconsin schools of nursing, chief nursing officers (CNOs) of hospitals and hospital systems, and non-profit system directors who had knowledge of the number of nurses serving on their respective boards (WCNb, 2014). The Targeted Board Survey is a 5-item survey developed by content experts from the Wisconsin Center for Nursing [WCN] and informed by a review of the literature related to nurses serving on boards (WCNb, 2014). Similar to national findings, the investigators found that nurses in Wisconsin were largely underrepresented (1.3%) as members of health-related BODs in the state (WCN, 2014a; 2014b).

The purpose of the current study was to enumerate RN participation on boards of Directors in Kansas, including the types of boards RNs are serving on and the geographic region in which they serve. Study findings are used to guide recommendations for RN participation on BODs throughout Kansas.

Methods

This study used a quantitative descriptive survey design, with a modified version of the Targeted Board Survey from Wisconsin (WCN, 2014b), re-named the Targeted Board Survey-Kansas (TBS-K). The TBS-K included regional location of the board, age of RN(s) serving, and identification of board member position as voting or ex officio. Representatives of specific boards, including schools of nursing academic boards, hospital and health systems boards, and health-related governor-appointed boards and commissions in Kansas, were invited to participate. Participants in this study included deans and assistant deans from accredited Kansas schools of nursing, CNOs of hospitals and health systems, and executive directors of health-related governor-appointed boards, commissions, and committees. For the current study, health-related boards was defined as BODs, commissions, or committees that have the potential to impact or influence the health of Kansans (i.e., hospital BODs, pharmacy boards, healing arts boards, housing commissions).

Prior to implementation, the study was approved by the University of Kansas Medical Center Internal Review Board. A letter of invitation and link to the TBS-K was emailed to all potential participants as previously described. In addition, directors of governor-appointed boards were contacted via phone in an attempt to increase participation among this group. A link to the TBS-K also was posted on the Kansas Action Coalition (KSAC) website and the KSAC Facebook page. The TBS-K survey was administered via Survey Monkey, and all responses were recorded anonymously. Data were collected from May through September 2015. SPSS Statistics 22 was used to calculate descriptive statistics.

Results

Of the 62 survey respondents, two were removed due to incomplete data. The final sample of 60 individuals responded about 60 health-related boards. Respondents described 65 RNs serving on those boards. Because of the sequential invitation technique, it is not possible to calculate a total response rate. However, we estimated the response rate for hospital and health systems BODs to be 17.6%, as determined by dividing the number of responses related to hospital and health systems BODs (n = 39) by the total number of KHA hospitals and health systems (n = 221) at the time of this study. All geographic regions of Kansas were included in the BODs represented by these 65 nurses.

Information was provided for 36 hospital boards, three health systems boards, eight nursing education boards, three governor-appointed boards and commissions, and 10 health-related board types identified as 'other'.

Nearly two-thirds (n = 38, 64%) of all participating boards had at least one RN serving on the board; 36% (n = 22) had no RNs serving. Over half (56%, 20/36) of hospital boards; 100% (3/3) of health systems boards; 90% (9/10) boards identified as 'other'; and 75% (6/8) of nursing education boards had at least one RN serving. There were no RNs serving on governor-appointed boards (0/3).

During study recruitment, two themes emerged from phone contact with governor-appointed board members. Participants either: (a)

reported that they had not considered nurses serving on their boards, but would be interested in them serving, or (b) expressed that nurses were not needed because the board was responsible for decisions that were not viewed as related to health (i.e., housing).

About half (51%, 33/65) of the RNs serving on Kansas boards held full board member positions with voting rights. Similarly, half (50%, 15/30) of RNs identified as serving on a hospital board were identified as having a full board member role, while 11 were identified as having a role without voting authority (i.e., board member ex officio or officer), and 4 respondents did not specify. The majority (62%) of RNs serving were over the age of 50, with 28% being older than sixty. Over half (57%, 33/58) of RNs had been serving on their respective board for 2 – 5 years, while 24% (14/58) had been serving longer than five years. Almost all RN board members were female (97%, 63/65) and Caucasian (98%, 64/65).

Discussion

Findings from the current study show that two-thirds (64%) of the health-related boards in Kansas include at least one RN board member. This finding is quite different than what has been reported from Wisconsin (1.3%, WCN, 2014a) or nationally (2-6%, Prybil, 2009; Prybil, Dreher, & Curran, 2014). The discrepancy may be due in part to using a sequenced approach for distribution of the study participation invitation. We used intermediary persons with access to KHA CNO email addresses or dean and associate dean email addresses to distribute the survey invitation. Participants who self-selected to participate may over-represent the number of RNs serving on health-related boards in Kansas. Participants who knew of a nurse serving may have been more interested in sharing this information than those who did not.

Higher RN participation on boards in Kansas may be attributable to the emphasis placed on nurses as leaders in Kansas nursing curricula. Nursing programs in Kansas typically include a strong focus on leadership development (Martin, Godfrey, & Walker, 2015; Peltzer, Teel, Frank-Ragan, & Nelson-Brantley, 2016), which may result in nurses seeking leadership positions. Furthermore, because Kansas is largely rural, there may be a greater propensity for nurses to serve in leadership roles in general. Additional studies are needed to explore this unexpected finding. If the finding is replicated in future studies, Kansas may serve as a model for strong RN representation on BODs. Although findings of this study identified a greater percentage of RNs serving on BODs in Kansas, many (42%, 11/26) of the RN board members held positions that lacked voting authority. This finding illustrates the continued need to remove barriers that limit nurses from engaging as full partners in health care policy. Similar to the findings in the Wisconsin study, our study found the presence of nursing education boards with no nurses serving (2/8). This could be partly due to some schools offering degree programs beyond nursing. Nonetheless, decisions about nursing education programs are being made without the contributions of a nursing board member.

Also like the Wisconsin study, our study found that RNs serving on boards were overwhelmingly Caucasian and female. These findings point to the limited diversity among nurses in key leadership positions and further support the IOM's (2011) recommendation to build a more diverse workforce, not just at the bedside, but in settings from the bedside to the boardroom. Furthermore, the majority (62%) of RNs serving on boards in this study were over the age of 50, and only five RNs (7.7%) were between the ages of 31 and 40. These findings indicate that we not only have an aging workforce in practice settings, but also an aging cadre of nurses serving in key leadership positions. Efforts should focus on succession planning and leadership development for diverse nurses of all ages.

Most striking was the absence of nurses serving on health-related governor-appointed boards and commissions. Conversations that took place with members of governor-appointed boards during study recruitment highlight two important takeaways. First, nurses would be a welcomed addition to many boards of directors. Second, nurses could bring a valuable perspective to boards by expanding traditional views of health and illness to include other important social determinants of health. Now more than ever, RN perspectives are needed.

This study is the first to enumerate RN participation on boards of directors in Kansas, including the types of boards RNs are serving on and the geographic region in which they serve. Findings of this study indicated that RN participation on hospital, health system, and other health-related boards is higher in Kansas than in other areas of the nation. However, many RNs serving on boards lack voting authority, which limits their ability to influence change. Furthermore, RNs are absent from governor-appointed health-related boards. The RNs serving on BODs in Kansas are overwhelmingly Caucasian, female, and mid to late career. Concerted efforts are needed to prepare the next generation of nurse leaders and to diversify nursing leadership to ensure that the health care needs of all Kansans are represented. Nurses bring important perspectives to boards to address their greatest challenges, including cost, quality, safety, and a holistic understanding of determinants of health. Nurses need to be educated regarding the importance of serving on boards and more engaged in seeking out board leadership opportunities. Only then will nursing meet the call to lead change and advance health in Kansas.

Dr. Heather Nelson-Brantley is a clinical instructor at the University of School of Nursing. She is a Jonas Nurse Leader Scholar and co-investigator for the National Database of Nursing Quality Indicators (NDNQI®). Dr. Nelson-Brantley's research focus is organizational systems development and nursing leadership, with emphasis on improving critical access hospitals, as well as nurse participation on Boards of Directors. Dr. Nelson-Brantley has served on several nursing association boards, including the Sigma Theta Tau International Delta Chapter and the American Association of Critical-Care Nurses Greater Kansas City Chapter.

Dr. Cynthia Teel is a Professor and Associate Dean, Academic Affairs at the University of Kansas School of Nursing. She is a Fellow of the American Academy of Nursing and a Robert Wood Johnson Executive Nurse Leader Fellow. Dr. Teel is Co-Lead of the Kansas Action Coalition and has been instrumental in efforts to implement the Institute of Medicine's Future of Nursing recommendations in the state of Kansas.

Table 1

Recommendations and Action Steps for RN Participation on BODs in Kansas	
Recommendation	**Action Steps**
Develop nurses' knowledge, skills, and interest in seeking board leadership positions.	▪ Develop a Nurses on Boards webinar series to prepare nurses to serve on boards. ▪ Provide mentoring and shadowing opportunities for nurses interested in board leadership. ▪ Advocate for nurses to seek board positions with full voting authority.
Increase nursing participation on governor-appointed and other community boards and commissions.	▪ Raise awareness among governor-appointed health-related boards through face-to-face conversations, emails, and printed brochures about the value of the nursing perspective on boards. ▪ Raise awareness among nurses regarding the value of serving on governor-appointed and community boards as well as open board positions through the KSAC website, email distribution list, social media, personal communication, and nursing conference presentations. ▪ Identify nurses qualified to serve on governor-appointed and community boards and commissions and encourage them to seek out open positions matching their areas of interest or expertise.
Increase racial, ethnic, gender, and age diversity among nurses participating in board leadership.	▪ Create board leadership development programs for younger RNs (30-40 years of age), male RNs, and ethnically diverse RNs. ▪ Provide mentoring and shadowing opportunities for younger RNs (30-40 years of age), male RNs, and ethnically diverse RNs interested in board leadership. ▪ Identify diverse RNs qualified to serve on health-related BODs and encourage them to seek positions matching their areas of interest or expertise.
Expand data collection efforts for tracking progress on efforts to increase nursing representation on health-related boards in Kansas.	▪ Collect data regarding community-related boards (i.e., city water commission, after school programs, K-12 education boards). ▪ Establish a link on the KSAC website for continuous data collection and tracking of nurses currently serving on boards and commissions in Kansas. ▪ Develop a routine mechanism for reporting collected data to the NOBC and CFA.

Note. RN = registered nurse; BODs = Board of Directors; KSAC = Kansas Action Coalition; NOBC = Nurses on Boards Coalition; CFA = Campaign for Action.

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41st Annual
Kansas State Nurses Association

Legislative Conference

February 23, 2017

Ramada Convention Center
420 SE 6th Ave.
Topeka, Kansas 66607

www.ksnurses.com/event/legislativeday

Agenda

8:00 a.m.	**Check-In Registration / Light Breakfast Bar** Hotel Lobby Atrium
9:00 a.m.	**Opening Remarks** Linda Becker, KSNA state director Angella Herrman, KSNA president Cassie Ledgerwood, KANS president
9:15 a.m.	**2017 Legislative Platforms** Carol Moore, PhD, APRN, CNS, legislative chair Tana Myers, KANS legislative chair
9:45 a.m.	**Understanding the Legislative Process** Carol Moore, PhD, APRN, CNS, legislative chair
10:00 a.m.	**Break**
10:30 a.m.	**Keynote Address: Disparity in Voter Turnout** Mark Joslyn, PhD, director of graduate studies University of Kansas - Political Science
11:30 p.m.	**Lunch Break**
12:30 p.m.	**Motivational Speaker: A.I.M. of Nursing Practive** Josh Witt, BSN, Critical Care at St. Luke's Hospital in Kansas City, Missouri
1:30 p.m.	**Professional Panel: Future of Nursing in Kansas**
3:00 p.m.	**Break**
3:15 p.m.	**Be the Force to Shape Policy in Kansas** Betty Smith-Campbell, PhD, APRN, RN, professor at Wichita State University
4:00 p.m.	**Wrap Up, Evaluations & Door Prizes**
4:15 p.m.	**Adjourn**

Participants are eligible to receive 4.5 nursing contact hours.

The Midwest Multistate Division is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

MK-KS16-064

Individual Registration Form

41st Annual
Kansas State Nurses Association
Legislative Day
February 23, 2017
Ramada Convention Center · Topeka, Kansas

Name: _____

❑ I am a first time attendee.

Address: _____
Street *City* *State* *Zip*

Daytime Phone: _____ Evening Phone: _____

Email: _____

Registration Fees:
The registration fee includes soup/salad/potato bar lunch and conference materials.

❑ Association Members	$60.00	Member #: _____
❑ Non-Member	$75.00	
❑ Grad Student	$60.00	School: _____
❑ Undergrad Student	$35.00	School: _____

Total: $_____

Payment Method:
- ❑ Check enclosed (Payable to the Kansas State Nurses Association)
- ❑ Charge to [ ] MasterCard [ ] Visa [ ] American Express [ ] Discover

Card #: _____ Exp. Date: _____ CVV: _____
3 digit code on back

Cardholder Name: _____ Billing Zip: _____

Cardholder Email Address *(for receipt of payment)*: _____

By registering I give my permission to distribute my name to conference attendees and vendors and to allow any photos taken during the event by the Kansas State Nurses Association to be used in future web and printed publications. If I prefer not to be included, I will include written request with my registration to opt out.

Deadline For Registration – February 13, 2017

If mailing payment, please include this completed form and send to: Kansas State Nurses Association, 1109 SW Topeka Blvd., Topeka, Kansas 66612-1602, or you may fax the completed form to 785.233.5222.

REFUND/CANCELLATION POLICY: *We encourage you to send a qualified substitute if you cannot attend. Registration fees, less a $25 enrollment processing fee, will be refunded to participants who cannot attend and notify the Kansas State Nurses Association in writing of the cancellation no less than ten (10) business days prior to the date of the activity. No refunds will be made after that date. There will be no refunds due to inclement weather.*

Questions? Call 785.233.8638 or email ksna@ksnurses.com.

Kansas Nurses Foundation Update

The Kansas Nurses Foundation (KNF) will be present once again at the KSNA Legislative Conference scheduled for Thurs., Feb. 23, at the Topeka Downtown Ramada Convention Center. Please stop by our tables to celebrate our 2016 scholarship winners and view the assortment of raffle items to be given away. If anyone has an item to donate for the raffle, please bring it with you to the conference and drop it off at the KNF tables. Raffle tickets will be $1 each or 6 for $5 with all proceeds going to support nursing education scholarships for students attending Kansas schools of nursing.

Speaking of scholarships, the 2017 scholarship applications are due to KNF on or before June 30. The application is available online at ksnurses.com/knf and should be mailed to the KNF Scholarship Committee, P.O. Box 3899, Topeka, KS 66604.

Last year we had interest from 60 students with 22 completed applications and 18 scholarships awarded. That number was up from 14 the year before due to increased donations through special events, response from donors to our Florence Nightingale Annual Giving Fund, and support from KNF endowed scholarships.

Last year KNF trustees participated in three efforts to secure unrestricted funds: the annual KSNA Legislative Conference, the annual dinner & silent auction held at the KSNA Membership Assembly, and the Topeka Gives event sponsored each year by the Topeka Community Foundation. Most recently, KNF has been approved as a recipient of donations from The Kroger Company Community Rewards Program. Each quarter, KNF receives a check from The Kroger Company based on Dillon's shoppers who have registered in their Community Rewards Program. It is easy to register as a partner in this effort for KNF. Simply go to the Dillon's website at www.dillons.com and select Community Rewards. Complete the requested information. Select the Kansas Nurses Foundation NPO number 12379 and you are a participant in this special program. Every time you shop at Dillon's use your free Plus Card and a percentage of your total will be applied to the KNF account. If you don't already have a Plus Card you can sign up for one online or at the store. Won't you please join us in this convenient way to support KNF nursing scholarships?

Many of you in the Wichita television viewing area have likely seen the KSN-Brad Pistotnik Honor A Nurse program advertisements and announcements. Each month a nurse is recognized by patients who are especially appreciative of that nurse's care and nominates them for a $1,000 donation to KNF by Attorney Brad Pistotnik. Since the program began the following nurses have been so honored: Sarah Willits (August), Vickie Cranston (September), Jessica Marberry (October), Linda Terrell (November), and Lisa Gerdes (December). You are welcome to nominate a colleague for this honor by visiting the KSN website at ksn.com/honor-a-kansas-nurse and completing the requested information. The program continues through July 2017.

We are grateful to everyone who helps us increase funding for nursing scholarships. Listed below are the donations received Jan. 1. 2016 - Dec. 31, 2016. An asterisk denotes a board trustee. Information in parenthesis indicates a specific scholarship fund or tribute gift in memory/tribute of either a deceased individual or in honor of someone. Every effort has been made to include all donations; occasionally, an omission may inadvertently occur. Please accept our apology and send an email to knf@ksnurses.com to help us correct any errors.

Scholarship Restricted Support

- The Dlabal Foundation (Rose Mary Dlabal Fund)
- Ida J Finney (KSNA District 10 Fund)
- Terry and Janice Jones (KSNA District 10 Fund)
- Kansas Association of Nurse Anesthetists (George DeVane Fund)
- KSNA District 2 (District Fund)
- KSNA District 6 (See, Newman, Lee Funds)
- KSNA District 7 (Dorothy Astle Fund)
- KSNA District 18 (Norma Parker Fund)
- Carla A. B. Lee (Lee District 6 Fund)
- Martha Sanders (Morgan-Sanders Fund)*
- Greta Snell (Glenn and Greta Snell Fund)*
- John A. Walker (L. Joy Walker Fund)

Florence Nightingale Annual Giving Fund (Unrestricted)

Donor Level (through $99)

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- Jeffrey and Delyna Bohnenblust, Altamont
- Barbara Bridges, Shawnee (Bonnie Peterson)
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- Brad Pistotnik Law, Wichita

In-kind Donations (Activities/Events)
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- Greta Snell, Hutchinson*