Feature story:
The Blueprint for Improving Patient Care
Nursing-Sensitive Indicators
The years 2010 and 2011 were marked by many milestones at the University of Kentucky. We celebrated the College of Nursing’s 50th anniversary and currently are celebrating the 25th anniversary of the PhD Program and 10th anniversary of the DNP Program. At UK HealthCare, we opened Pavilion A and began the transition to our replacement facility. The new pavilion provides a wonderful environment for our interdisciplinary teams to care for the most complex and critically ill patients from across the Commonwealth. Pavilion A at Albert B. Chandler Hospital, Chandler Hospital, UK Good Samaritan Hospital, Kentucky Children’s Hospital and our diverse ambulatory sites provide excellent learning laboratories for our nursing students and other learners on the interdisciplinary team. As we work toward an environment conducive to interprofessional education, we also continue to work toward a clinical leadership model that leverages the strength of the collaboration of interdisciplinary teams to produce the best possible clinical outcomes.

The college and UKHC are working as close partners to accomplish the recommendations of the 2010 IOM report, “The Future of Nursing.” One of the recommendations is to increase the number of baccalaureate-prepared nurses. Our shared goal is to increase the percentage of BSN-prepared nurses at UKHC by 5 percent to 7.5 percent annually. Additionally, we work closely to ensure that new BSN graduates have the technical and cognitive skills necessary for success in today’s complex environment.

The IOM recommendations around increasing doctorally prepared nurses and interdisciplinary partnerships are well underway. The BSN-DNP and the MSN-DNP Options continue the work of ensuring an excellent clinical and leadership experience for doctoral students. This work is essential as all health care providers are expected to function at their highest levels within interdisciplinary teams. The cooperative work between the college and UKHC is further manifested by the study of supply and demand of key specialty providers. One example is the college’s intent to provide a crosswalk for primary care pediatric nurse practitioners to become acute care pediatric nurse practitioners — a critical resource for Kentucky Children’s Hospital’s growing volume and complexity of patients.

Our pride in UK and the contribution of nursing to the success of our dynamic care model is palpable in our third edition of In Step. Nursing continues to provide clinical leadership, contribute to new knowledge and educate some of the best students. We hope the stories resonate with you and provide insight into our work, our vision and our realization of expectations for the nurses of tomorrow. As our health care landscape continues to change and the pace of change accelerates, we intend to provide a learning and practice environment that will support the care model of the future.
New Patient Care Facility Enhances Patient-Driven Care

As part of UK HealthCare’s plan to become a premier regional medical center, the new patient care facility at UK Albert B. Chandler Hospital is changing minds about how health care should best be delivered. More importantly, it’s also changing lives. The facility is designed to support patient care for the next 100 years, concentrating on cancer, trauma, neurosciences, organ transplantation and pediatric subspecialties.

“This new Pavilion A, which includes the latest innovative features and is a benchmark for beautiful and functional design, is certainly impressive. But what about this new patient care facility is so vastly different from other medical systems and how exactly is it revolutionizing patient care at UK?”

The answer can be found in patient outcomes.

“The major difference is that we have created platforms of care that more closely resemble a service line-type approach to care,” explains Chief Nurse Executive Colleen Swartz, DNP, MBA, RN, NEA-BC, UK HealthCare. She cites the example of how in the past ICU beds were nested together in an ICU tower, which caused a lot of moving of patients and handover from one caregiver to another. “Not only was the patient physically moving a lot, but handovers create risk for error and can create an extension of stay. New caregivers would constantly be relearning about the patient, and that, plus physically moving the patient, takes more time,” says Dr. Swartz.

Now, each patient care floor is focused on a specialty service, such as neurosciences or trauma and acute care surgery, allowing staff with special skills and experience to be focused in a particular area. All patient floors are designed to accommodate acute, progressive and intensive care patients, minimizing the need to transfer patients to other areas. The result is more of a team atmosphere where nurses share skill sets as a cohesive unit, centered on the patient.

“Buildings provide a setting, an opportunity, the mechanics of care; health care is about human interaction, the human-to-human touch that brings healing, comfort and confidence at times of uncertainty and pain,” says Ann Smith, MPA, FACHE, chief administrative officer, Chandler Hospital. “The real impact of the care delivery model in the new facility is about the professionals providing the care. Buildings provide a setting, an opportunity, the mechanics of care; health care is about human interaction, the human-to-human touch that brings healing, comfort and confidence at times of uncertainty and pain. This new building and its technology are tools in the hands of talented people who will be using it to provide advanced specialty care, which UK HealthCare is uniquely equipped to offer.”

—Ann Smith, MPA, FACHE, Chief Administrative Officer, Chandler Hospital
Dr. Chang. “What’s transparent to the patients is a redesigned workflow that aims to improve care and the patient experience.”

Every inch of the new patient care facility was designed with safety and quality of care in mind, including bedside computers enabling nurses to spend more time with patients, improved access to supplies and equipment, provider workstations outside patient rooms that give nurses line-of-sight patient views, and patient lifts for special needs patients.

When it came to providing the very best in health care, every piece of equipment, down to the chairs selected for visitors, was carefully chosen by the staff who work in the environment and is designed with patient and staff safety and comfort in mind,” says Ms. Bush.

Built in phases, Pavilion A will be fully completed in six to ten years. Prior to opening the first two patient floors in May 2011, the new facility had been in the planning stages for several years. To say it is state of the art is a given, but the facility was also designed with the healing effects of beauty in mind. The finished areas evoke a natural setting that is uniquely Kentucky with water features and native plantings. As part of the donor-supported UK Area in HealthCare Programs, Pavilion A features art in all forms, including works of commissioned artists in key public locations, a core collection of art with a Kentucky connection, music therapy and a performing arts program for all UK HealthCare patients.

The new center’s main objective is to involve patients and families in their care, empower them with knowledge of how to obtain the best possible health outcomes and prevent adverse events by educating patients and families, visitors, students, clinicians and the community. The center is being developed to meet the needs of all patient populations, including those with low health literacy skills and complex medical questions.

“The state-of-the-art center offers resources for every level of understanding, including pamphlets with pictures, books, audio books, videos, interactive computer programs, models, posters, health applications for smart phones and tablet computers, newsletters, health and wellness displays, anatomical models and more. All are available free of cost. Personal assistance is provided by caring medical librarians and nurses, so patients and their families can find the information they need to be well-informed participants in their health care decisions, something health care providers believe makes a tremendous difference.

“The Patient Education Center has provided access and availability to our patients and the people who care about them so that they can learn more about the process, the disease and home care. And it helps to allay some of their fears,” says Colleen Smurr, DNP, MBA, RN, NEA-BC, UKHC chief nurse executive.

Indeed, multiple studies show that educated patients are more highly engaged in the healing process. “The more the patients understand their illnesses, the better they could participate in their own care, which leads to better outcomes,” agrees Phillip Chang, MD, medical director of trauma and acute care surgery, UKHC.

Recommendations from The Joint Commission of Accredited Hospital Organizations, the Institute of Medicine, and Agency for Healthcare Research and Quality state that health care systems must make effective patient education and communication an organizational priority. It is of utmost importance to provide written resources that patients can understand and use. Clinicians should also be trained in health literacy principles so that they provide clear verbal communication and ensure learning has occurred by using “teach back” or “show back” techniques. A Nurse Patient Education Certification Course is offered through the center to educate nurses on the most effective way to teach. Those patient education-certified nurses develop work processes and mentor nurses on their units to adopt best practice patient and family education.

“The Patient Education Center also serves as the central repository for all patient education for the entire UK HealthCare enterprise. Information technology is used to support clinicians with patient education resources at point-of-care that meet The Joint Commission, patient safety and core measures standards. This online patient education resource is integrated into the electronic medical record across UK HealthCare and consists of simple instructions in English and Spanish that are easy to understand. The goal is to create a patient portal for access to education in video or written format from home.

In addition to health education resources, the center offers a business center with computers, printers and free Internet access, as well as free copying and faxing. Pictures viewing rooms are available for video, DVD and Internet programming.

The new center is also home to the UK Arts in HealthCare collection of whimsical Kentucky folk art, curated by the Kentucky Folk Art Center. More than a dozen pieces of art on display, including several sculptures, all with a Kentucky theme.

It is hoped that the center will continue to play a valuable role in patient and family educational opportunities, even as the new health care facility continues to expand in coming years. “With the Jacobs’ generous gift, the new Don and Cathy Jacobs Health Education Center is poised to serve generations of Kentucky families in their mission to achieve greater health and well-being,” says Dr. Karpf. Indeed, the center is already a vital part of the new patient-centered model.

“I see the results every day of empowering patients and families with the knowledge they need to be able to make informed health decisions, reopen the world to their health care experience,” says Ms. Dunn. “People come back to visit after time to show their gratitude and tell their stories of how the information they received from the Don and Cathy Jacobs Health Education Center made all the difference in the world to their health care experience.”
UK HealthCare Nurse Promotions and Transitions to Leadership Positions

July 1, 2010 – December 1, 2011

Lara Blake, BSN, RN
Service Line Manager, Chandler Hospital, Perioperative Services

Alicia Carpenter, MSN, RN
Clinical Nurse Specialist, Chandler Hospital, Nursing Administration

Teresa Chase, MSN, RN
Staff Development Specialist, Chandler Hospital, Nursing Practice Improvement

Kathy Disney, MSN, RN, APRN, ACNS-BC, CCRN, C. PeD
Staff Development Specialist, Chandler Hospital, Nursing Practice Improvement

Linda Clements, MSN, RN, CCNS
Clinical Nurse Specialist, Chandler Hospital, Nursing Administration

Kathy Daniels, MSN, RN, CNOR
Perioperative Services Director, Associate, Chandler Hospital, Perioperative Services

Julia deVerges, BSN, RN
Perioperative Services Director, Associate, Good Samaritan Hospital, Perioperative Services

Jennifer Forman, BSN, RN
Patient Care Manager, Good Samaritan Hospital, 4 Main, Medical/Surgical/Telemetry

Pat Garrett, BSN, RN
Utilization Review Team Lead, UK HealthCare, Utilization Review

Lynn Gentry, BSN, RN
Patient Family Services Manager, UK HealthCare, Continuum of Care Services

Susan Gray, BSN, RN, CNOR
Staff Development Specialist, Chandler Hospital, Nursing Practice Improvement

Jane Hammons, BSN, RN
Staff Nurse Manager, Chandler Hospital, 5 South and 5 West Acute Care

Linda Holtzclaw, MSN, RN
Staff Development Specialist, Chandler Hospital, Nursing Practice Improvement

DeeDee McCalle, BSN, RN
Staff Nurse Manager, Chandler Hospital, 6 East and 6 South Progressive Care

Gwen Moreland, MSN, RN, NE-BC
Nursing Operations Administrator, UK HealthCare, Neonatal Care and Neonatal ICU Services

Judy Niblett, BSN, RN, NE-BC
Patient Care Manager, Chandler Hospital, 2 Medicine ICU and Central Monitoring Station

Carol Noriega, MSN, RN, CEN
Staff Development Specialist, Chandler Hospital, Nursing Practice Improvement

Donna Norton, MSN, BSN, BS, RN
Perioperative Services Enterprise Director, UK HealthCare, Perioperative Services

Kate Orman, BSN, BS, RN
Staff Development Instructor, Chandler Hospital, Nursing Practice Improvement

Kim Pennington, BSN, RN
Nursing Operations Administrator, UK HealthCare, Gill Heart Institute

Leah Perkins, BSN, RN
Patient Care Manager, Pavilion A, Neuroscience Services Tower One

Matthew Proud, BSN, RN, CEN
Patient Care Manager, Chandler Hospital, Emergency and Trauma Services, Adult Emergency Center Tower Two

Trish Seabolt, MN, MA, RN
Informatics, UK HealthCare, Informatics, Information Technology

Katherine Semiones, BSN, RN
Patient Care Manager, UK HealthCare, Hospital Command Center

Katie Shreve, MA, BSN, RN
Patient Care Manager, Kentucky Children’s Hospital, Acute Care Pediatrics

Suzanne Springgate, BSN, RN
Nursing Operations Administrator, Kentucky Children’s Hospital, Inpatient Pediatric Care

Darlene Spalding, MSN, RN
Senior Nurse Administrator, Good Samaritan Hospital, Administration

Carla Teasdale, MSN, RN
Informatics, UK HealthCare, Informatics, Information Technology

Heather Vance, BSN, RN
Patient Care Manager, Pavilion A, Neuroscience Services Tower Two

Laura Williams, Master’s Certificate in Health Informatics, BSN, RN
Informatics, UK HealthCare, Informatics, Information Technology

Lisa Butcher, BSN, RN
Patient Care Manager, Kentucky Children’s Hospital, Acute Care Pediatrics

Jamie Cross, BSN, RN
Patient Care Manager, Chandler Hospital, Clinical Decision Unit

Jessica Hutchins, BSN, BA, RN
Patient Care Manager, Kentucky Children’s Hospital, Acute Care Pediatrics

Jami Kyle, BSN, RN
Clinical Manager Senior, UK HealthCare, Internal Medicine and Divisions-Cardiology

Janine Lindgreen, MSN, RN-C, TNCC
Clinical Nurse Specialist, Chandler Hospital, Nursing Administration

Julie Mercer, BSN, RN
Control Desk Manager, Chandler Hospital, Perioperative Services

Katherine Potest, ADN, RN
Clinical Manager Senior, UK HealthCare, Internal Medicine and Divisions-General

Patricia Robbins, BSN, RN
Service Line Manager, Chandler Hospital, Perioperative Services

Crystal Spears, BSN, RN
Service Line Manager, Chandler Hospital, Perioperative Services

Robin Stovall, MBA, ADN, RN
Nurse Clinician Manager, UK HealthCare, Rehabilitation Medicine

Anita Taylor, BSN, RN
Patient Care Manager, Chandler Hospital, NCC, Inpatient Obstetrics

Good Samaritan nurses earn Pathway to Excellence® designation

The nurses at UK Good Samaritan Hospital have achieved Pathway to Excellence designation from the American Nurses Credentialing Center (ANCC). This recognition is one which community hospitals may choose to seek as a way of evaluating and improving their nursing practice. This is an important preliminary step we needed to take toward a combined effort on the part of UK Albert B. Chandler and UK Good Samaritan hospitals to seek Magnet designation for all hospital nursing in the future.
**UK College of Nursing Promotions and Transitions**

Frances Hardin-Fanning, PhD, RN
Frances Hardin-Fanning, PhD, RN, completed her PhD from the UK College of Nursing in 2011 and was promoted to assistant professor in a tenure-track position. A three-time alumnus of the college, Dr. Hardin-Fanning joined the faculty in 2005 as a lecturer in the undergraduate program. In 2009 she received the college’s Louise Zagier Nursing Faculty Award. Her research focuses on nutrition in Eastern Kentucky, including the effects of a Mediterranean-style dietary pattern on cardiovascular disease risk.

Dorothy Brockopp, PhD, RN
Dorothy Brockopp, PhD, RN, professor, retired in December 2011. She held a joint appointment in the Department of Anesthesiology in the College of Medicine. Dr. Brockopp received her BS, MSN and PhD from the State University of New York at Buffalo. From 1999-2007 she served as assistant dean for undergraduate studies and provided leadership in establishing an exceptional traditional BSN Program. Dr. Brockopp has also taught and advised students in the DNP and PhD programs. From 2005-2007 she served as chair of UK’s President’s Commission on Women. Brockopp’s research on behavioral issues related to chronic and life-threatening illness has appeared in a variety of journals and she has presented extensively. Dr. Brockopp served for seven years as a research consultant for Albert B. Chandler Hospital. Since 2007, she has served as the evidence-based practice consultant at Central Baptist Hospital in Lexington. Her contributions were recognized in 2011 when she received the Sigma Theta Tau International Evidence-Based Practice Award.

Terry Lennie, PhD, RN, FAHA, FAAN
Terry Lennie, PhD, RN, FAHA, FAAN, associate dean for PKD Studies and co-director of the Rich Heart Program, has been an associate professor. Dr. Lennie joined the UK College of Nursing in 2003. He teaches in the PhD Program and advises PhD students. He is internationally known for his program of research that focuses on the development of scientifically based interventions to optimize nutritional intake in patients with cardiovascular disease, with a special focus on heart failure. He recently received a $1.6 million grant from the NIH, National Institute of Nursing Research to study non-pharmacologic interventions to reduce symptoms of heart failure. Dr. Lennie and his team of co-investigators will test the effects of a six-month intervention of dietary sodium reduction combined with supplementation of lysophosphatidyl ethanolamine and omega-3 fatty acids on heart failure symptoms, health-related quality of life, and time to heart failure hospitalization or death.

**UK College of Nursing Upcoming Events**

March 1-3: Commission on Collegiate Nursing Education Site Visit
The UK College of Nursing will host a five-member Commission on Collegiate Nursing Education (CCNE) team and a representative from the Kentucky Board of Nursing for an on-site evaluation March 1 through March 3. The evaluation is focused on the baccalaureate degree program in nursing, master’s degree program in nursing, and Doctor of Nursing Practice Program. The college’s self-study, completed in preparation for the on-site evaluation, is available on the college’s website at [http://academics.uky.edu/ukcon/pub/NewEvents/Publications/Pages/Publications.aspx](http://academics.uky.edu/ukcon/pub/NewEvents/Publications/Pages/Publications.aspx).

March 11: College of Nursing Caring Society Reception 5:30-7:00 p.m., University of Kentucky Art Museum
Donors who have supported the College of Nursing are invited to a reception hosted by Dean Jane Kirschling. The Caring Society recognizes donors who have given or pledged $5,000 to the college or have included the college in their estate plans. Donors will have the opportunity to enjoy a wine-and-cheese reception and view the first traveling exhibition in the U.S. dedicated to the multi-layered work of Aboriginal artist and activist Richard Bell, one of Australia’s leading and most controversial artists. This event is complimentary and paper invitations will be sent in early 2012. If you are interested in learning more about how to become a member of the Caring Society, please contact Meizy Burton at [thankyou@uky.edu](mailto:thankyou@uky.edu) or (859) 323-6635.

March 21-4: College of Nursing Phonomath
Your support is vitally important to our mission of excellence in nursing education, research, practice and service in an ever-changing health care environment. We hope you will answer the UK student’s phone call and say, “Yes! I want to invest in future nurses!”

**Congratulations**

Lynne Hall, DrPH, RN
Lynne Hall, DrPH, RN, Marcia A. Dake Professor of Nursing Science, retired in October 2011. She held a joint appointment in the College of Medicine Department of Behavioral Health and the College of Public Health. Dr. Hall completed her BS and MSN from Clemson University and her DrPH from the University of North Carolina (UNC). Prior to joining the UK College of Nursing faculty in 1985, Dr. Hall completed a two-year post-doctoral fellowship in maternal-child health from UNC. Her research on the health of mothers and their young children has been reported in a variety of journals and she has presented at numerous regional, national and international conferences. In 1996 Dr. Hall assumed the role of assistant dean for research and director of graduate studies for the PhD Program. In 2007 she was named associate dean for research and scholarship. Her unwavering commitment to preparing the next generation of nurses was recognized in 2008 when she received the William B. Staggard Award for Outstanding Contributions to Graduate Education from the University of Kentucky Graduate School.

Kathy Wheeler, PhD, RN, APHN
Kathy Wheeler, PhD, RN, APHN, assistant professor, was inducted as a fellow of the American Academy of Nurse Practitioners in 2010.

March 30: College of Nursing Student Scholarship Showcase
This annual event showcases undergraduate and graduate nursing student scholarship, pedagogy and power presentations in all three colleges of Nursing, the Commonwealth of Kentucky’s Board of Nursing (CPNB) and UK HealthCare’s BSP Residents. For more information call the College of Nursing receptionist at (859) 323-5108 and check the news section of our website at [http://academics.uky.edu/ukcon/pub/NewEvents/Publications/Pages/Default.aspx](http://academics.uky.edu/ukcon/pub/NewEvents/Publications/Pages/Default.aspx).

April 13: UK College of Nursing Celebration of PhD 25th Anniversary and DNP 10th Anniversary
Watch for more information on our website.

May 4: Graduate Student Hooding Ceremony and Reception
10 a.m., Singletary Center for the Arts
Dean Jane Kirschling, faculty and staff invite you to attend the hooding ceremony and reception in honor of the December 2011 and May 2012 MNS, DNP and PhD graduates. Please feel free to join us for this special event.

BSN Pinning Ceremony
1 p.m., Singletary Center for the Arts
Dean Jane Kirschling, faculty and staff invite you to attend the pinning ceremony in honor of the May 2012 BSN graduates. Please feel free to join us for this special event.

May 10-11: 8th Annual Faculty Development Workshop
Hiary J. Boone Center, UK
This workshop brings together leaders of educators to network, validate and enrich nursing education. Topics will include clinical reasoning, writing across the curriculum, effective strategies for teaching online, case method instruction, test questions, evidence-based practice and integration of technology. The workshop is intended for both undergraduate and graduate nursing faculty, staff development, and other interested nurses. More information is available in the Continuing Education Live Events section of the college’s website at [http://academics.uky.edu/ukcon/pub/ContinuingEducation/LiveEvents/Pages/Default.aspx](http://academics.uky.edu/ukcon/pub/ContinuingEducation/LiveEvents/Pages/Default.aspx).
An environment that encourages nurse inquiry creates opportunity

While optimal patient health has always been the goal in nursing practice, there’s never been a greater interest in measuring the relationship of one on the other. Evidence-based practice is a key foundational element in health care today and it’s easy to see why. Patients are older and sicker. Medical issues are more complicated. As health care costs continue to rise, so does the demand for proof, backed by science, that a treatment, intervention or practice isn’t just a good way to go. It’s the best way.

“Hospitals are constantly challenged to demonstrate the value contribution just a good way to go. It’s the best way. Over time, we’ve become much more intentional about examining how that process works and how we can promote it to an even greater extent,” says Suzanne Prevost, PhD, RN, the interim coordinator of the college’s DNP Population and Organizational Systems Leadership Track, which is currently working on a study related to nurse managers. She says that the nurse manager is an important determinant of staff nurse satisfaction. “The studies have mostly been done from the perspective of the staff nurse. Few studies have examined the role of the nurse manager from their perspective.”

Practice Improvement Facilitator Robyn Cheung, PhD, RN, UK HealthCare, joined the medical center in fall 2011. A core element of her position is to support medical center nurses to find answers to their clinical questions, and when possible, to connect them with nursing faculty who have similar interests. Dr. Cheung wants to start by demystifying the whole notion of research, particularly for nurses on the front lines of care. “People hear a word like ‘research’ and immediately think bench research or randomized controlled trials,” she says. She prefers the term “inquiry,” something nurses do naturally. “Nurses come across things every single day and wonder — maybe not even consciously — ‘Does this work?’ ‘Is another way better?’ ‘Why are we using this supply?’ The key, she says, is taking those questions to the next, evidence-based level. ‘We want to help nurses take their ideas and insights and form them into clinical questions that can be measured, then help lead them step-by-step through the evidence-based inquiry process — and they’re all manageable steps.’

An environment that encourages nurse inquiry creates opportunity

Last year, Kathy Stephenson, MSN, RN, CNS, nursing division director, UK Good Samaritan Hospital, and other critical care nurse leaders from UK Albert B. Chandler Hospital needed help in creating a research proposal for a grant. Dr. Prevost put the group in touch with Susan Frazer, PhD, RN, associate professor, College of Nursing, a highly regarded scholar whose own research focuses on cardiovascular responses to critical illness and injury. Realizing the need for more time to work on the grant, the group turned to innomaniak to create a proposal for clinical care for managing pain and sedation in mechanically ventilated patients. “That’s my patient population, so I was especially interested,” says Dr. Frazer. The protocol itself, designed as an interdisciplinary team at the medical center, was implemented at Good Samaritan earlier this year. Ms. Stephenson and nurse leaders at Chandler wanted to research its efficacy on outcomes, both for patients and for nurses. Dr. Frazer helped the team frame the research and come up with the outcomes for measurement. Next, she’ll work with them to get IRB approval so they can begin collecting the data.

“Hopefully, some of the people involved in data collection, especially be staff nurses who are working on academic degrees, will be able to use or build on the experience in their studies,” says Dr. Frazer. At the end of 2011, the group was putting together an interdisciplinary team to participate in the research initiative, including staff nurses at Good Samaritan who Ms. Stephenson says are excited about the possibilities. “We’ve been part of UK HealthCare for four years now, and it has been wonderful to have the resources of the medical enterprise and the College of Nursing to draw on.” As a nurse educator and scientist, Dr. Frazer says the close working relationship between the college and the medical center are a plus for her role. “The people in critical care have been very instrumental in helping my students in their research projects and me in my research trajectory. At the same time, we’ve been able to help them optimize the way they care for patients. It’s a very nice collaboration.”

Above left: Kathy Stephenson, MSN, RN, CNML; and Jeremy Flynn, Pharm.D. Above right: clockwise from top right: Jeremy Flynn, Pharm.D.; Pam Blankenau, MSN, RN; Kathy Stephenson, MSN, RN, CNML; Theresa Creslakay, BSN, RN; CNML; Susan Frazer, PhD, RN; Doug Doyle, Pharm.D.; Katherine (Nicole) Jordan, BSN, RN; and Leah Hughes, BSN, RN.
Inquiry: Elopement

Elopement is a serious risk for hospitals, especially for those with older patients whose judgment may be impaired or patients whose behavioral health or medical issues affect sound decision-making. For hospitals located near populated areas and commercial areas where it’s easier to slip away or blend in unnoticed, the risks are even higher. Like most hospitals around the country, Good Samaritan’s elopement policy was focused primarily on response. “Nurses at Good Samaritan thought we could do better,” says Dr. Swartz. Their interest was the genesis, she says, for the development of a new elopement assessment recently titled Good Samaritan and Chandler.

Clinical risk manager for UK HealthCare, Paula Holbrook, JD, ADN, RN, led the multidisciplinary effort to look into elopement policy enterprise-wide, a far-reaching project that began more than a year ago. “Our overarching goal was to provide safe, compassionate care that mitigated our risk.” A secondary goal, she reports, was to come up with an assessment that would allow staff to identify those at risk and put safeguards in place to prevent elopement. Mrs. Holbrook coordinated research and an in-depth literature review to evaluate the evidence on elopement from a variety of perspectives, from nursing care to risk management to security practices. Her team then assembled the research and derived a scale to identify practices that had the most robust evidence behind them.

Eventually, an interdisciplinary group from both hospitals began forming on work to develop an evidence-based approach to elopement policies by identifying practices that had the most rigorous evidence behind them. Eventually, an interdisciplinary group from both hospitals began forming on work to develop an evidence-based approach to elopement policies by identifying practices that had the most rigorous evidence behind them. Eventually, an interdisciplinary group from both hospitals began forming on work to develop an evidence-based approach to elopement policies by identifying practices that had the most rigorous evidence behind them. Eventually, an interdisciplinary group from both hospitals began forming on work to develop an evidence-based approach to elopement policies by identifying practices that had the most rigorous evidence behind them.

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Inquiry: Pediatric Sedation

Kentucky Children’s Hospital began its pediatric sedation service in the late 70s to provide anxiety and pain relief to children undergoing painful and diagnostic procedures. The service, an innovation at the time in what is still the relatively new field of pediatric sedation, has been a major contributor to the national research in the field for the years. Cheri Landers, MD, associate professor, Department of Pediatrics, UK College of Medicine, and director of pediatric sedation, Kentucky Children’s Hospital, and Carrie Makin, BSN, RN, pediatric sedation coordinator at Kentucky Children’s Hospital, are among those contributing.

Before 2005 when Ms. Makin became the children’s hospital’s first pediatric sedation nurse, the physicians handled the service on their own. “We depended on nurses, but there wasn’t a nurse as a member of our team,” says Dr. Landers. “The formal data isn’t there to measure it, but I think our efficacy suffered and our numbers suffered when we were doing it alone.”

As a team, Dr. Landers and Ms. Makin developed a “dashboard” based on what they found works best but would like to see the rigor of evidence-based research to confirm it. “We’re doing has been adapted from anesthesia providers, but those aren’t always readily adaptable to surgery outside the operating rooms.”

Currently, there are no benchmarks for pediatric sedation, something Ms. Makin and Dr. Landers are working to change. Both are active in the Society for Pediatric Sedation (SPS), the international organization dedicated to fostering safety, quality, and a multidisciplinary approach to pediatric sedation. Ms. Makin, who serves on the SPS board, worked on a proof-of-concept national grant proposal that would allow the group to develop a consensus statement to help set pediatric sedation benchmarks. The grant was approved, and the first consensus meeting, held in Baltimore in November 2011, brought together a multidisciplinary group of sedation practitioners from across the nation, including Ms. Makin and Dr. Landers.

Ms. Makin, a two-time winner of the Dorothy Brockopp Nursing Research Award, says she’s grateful to UK HealthCare and particularly to Dr. Swartz for their support. “She has been a great mentor for me and has encouraged me to forge ahead with all the projects we have going on.” No doubt there will be more. Ms. Makin was recently asked to edit the nursing section for the SPS newsletter and has just finished her first article. “Much of what I know about being a pediatric sedation nurse has been self-taught because there’s just not much written about it in the literature,” she says. “Now it seems, I might be the one who can write it.”

“Whether results are good or bad, you want to know you’re reflecting the opinions of the group because then your strategies to improve the work environment will be more meaningful.”

—Nora Warshawsky, PhD, RN, UK HealthCare and Assistant Professor, College of Nursing

“Inquiry: Nurse Satisfaction

Last summer, Sharon Stratton, BSN, RN, manager of nurse recruitment, UK HealthCare, approached UK HealthCare Professional Development Council about forming a nurse retention subgroup of the council to investigate ways to support and encourage experienced staff nurses, especially at the two- to four-year level whose turnover can be high. “We want to retain nurses and clinical experts at UK HealthCare by discovering ways to keep them engaged and satisfied in the workplace.”

Several years ago, a committee made up largely of nurses managers and directors was formed to talk about the same thing, but it was concluded they really weren’t the right participants to have at the table. “We wanted this new retention group to be made up of staff nurses and to be completely run by staff,” says Ms. Stratton. “It was a huge outpouring of interest. “Several volunteered right away, and I’m getting calls from other nurses who want to participate. It’s exactly what the council hoped would happen!” Dr. Warshawsky will support the new task force as it evaluates the evidence on what is satisfying to nurses, particularly those with two or more years in clinical practice. One piece of evidence if it will be recommendations from a focus group study commissioned by the medical center that targeted senior staff nurses at Chandler and Good Samaritan. “Leadership received some good feedback centered on nurse retention and satisfaction, which the retention group will also be looking at,” says Ms. Stratton, noting that many of the suggestions that came out of the focus group have now been implemented, including clinical nurse experts and charge nurses to support clinicians at the bedside, rounding for outcomes and financial reimbursement before, rather than after, completing a certification.

“We haven’t done a great job of communicating changes that have come about based on nurse input,” says Ms. Stratton. Says Dr. Warshawsky, “Nurses are busy and have a lot going on. They don’t always know what or how change comes about, only that it does.” That, some say, could be one reason why nurses nationwide often rank power to change or impact hospital affairs very low on the National Database of Nursing Quality Indicators (NDNQI) practice environment scale. “That was one of our biggest areas for improvement in the 2009 NDNQI survey,” says Dr. Warshawsky. One caveat, she adds, is that low nurse participation in the 2009 survey limited its value as a true gauge. Participation in the 2011 NDNQI survey, however, was very high and that’s good news. “Whether results are good or bad, you want to know that the data reflect the opinions of the group because then your strategies to improve the work environment will be more meaningful.”

Evidence-based nursing practice is about more than just clinical interactions between nurses and patients, says Dr. Prevost. “It’s about taking an evidence-based approach in every decision we make, whether it’s how to staff a unit, how to make a purchasing decision or even how we teach our students at the college.” Dr. Prevost says getting more nurses engaged in evidence-based inquiry is key. “The end result is better results for patients,” she says. “That’s always the highest goal.”
As health care becomes more complex, the demands on advanced nursing practice are growing as well.

In October 2010, the Institute of Medicine (IOM) reported that the number of nurses prepared with a doctorate must double by 2020 to meet the nation’s needs. In response to the IOM comprehensive report on medical errors and report on health professions education, the American Association of Colleges of Nursing (AACN) published a position statement on the practice-focused doctoral degree in 2004, calling for a transition date of 2015 for the preparation of advanced practice nurses at the Doctor of Nursing Practice (DNP) level of education.

High standard. Short timeline. But the UK College of Nursing is already positioned to deliver.

The UK DNP Program is celebrating its 10th anniversary, and now there are two ways to enter the program. In addition to a post-Master of Science in Nursing (MSN) entry point, the school offers a post-Baccalaureate (BSN) entry option. Both culminate with the DNP degree.

“I am very proud that UK nursing faculty members continue to lead as early adopters in BSN-to-DNP education,” says Dean Jane Kirschling, DNS, RN, FAAN, College of Nursing. “The DNP curriculum optimizes the nurse’s ability to work in a very complex health care environment.”

In the BSN-DNP Option, students choose from six specialty tracks to expand their knowledge base and skill set in the specialization that most interests them. Although each track focuses on a population with targeted health problems, all the tracks share a curriculum of core courses. "Regardless of their population focus, it is extremely important today for nurses to understand how to assess the evidence we have for the best approach to care, how to apply it and how to evaluate it," explains Patricia B. Howard, PhD, RN, NEA-BC, FAAN, associate dean for MSN and DNP studies at the College of Nursing.

1. Adult-Gerontology Acute Care Nurse Practitioner Track

Melanie Hardin-Pierce, DNP, RN, ACNP, has been working at the College of Nursing since 1995 and is a board-certified acute care nurse practitioner. As the Adult-Gerontology Acute Care Nurse Practitioner Track coordinator, Dr. Hardin-Pierce knows that what sets UK’s program apart is an emphasis on the critical care management of adult and geriatric patients in high-acuity settings, which includes preparation for intensivist and hospitalist roles. “We also emphasize outstanding care of our ‘chronically critically ill’ patients so students are truly prepared to be successful in their careers as frontline providers,” she says.

Adult-gerontology acute care nurse practitioners focus on assessment, diagnosis and management of acute health problems. Graduates are prepared to care for acutely and critically ill adults. As members of a multidisciplinary health care team, practitioners work in intensive care, progressive care, other hospital units, specialty clinics and specialty physicians’ offices. “They are highly skilled individuals who must have a keen understanding about technology and evidence-based treatment of patients to provide tertiary restorative and preventive care to patients and their families. We prepare them to be leaders at the highest level of clinical practice,” explains Dr. Hardin-Pierce. Students in the program are surrounded by faculty who are all board certified and who actively practice in acute care settings. Stanley Tibong, BSN, RN, CCRN, is a second-year student in this track and currently works in a critical care setting. “I like to care for critically ill patients and be able to implement the best possible care using evidence-based practice to improve on their outcomes.”

After graduation, Mr. Tibong plans to continue to work in critical care and become a part-time educator as well. “I chose UK because of the outstanding faculty and the fact that it is the first school to offer the DNP Program, so it has more experience,” he says. He adds that the program is challenging but the faculty is very helpful and instills confidence while pushing for high standards.
Adult-Gerontology Clinical Nurse Specialist Track

Martha Biddle, PhD, RN, APRN, CCNS, has been a nurse for 24 years and has always worked in critical care. As the Adult-Gerontology Clinical Nurse Specialist Track coordinator, Dr. Biddle says her students have the desire to work in many areas of care, enjoying bedside nursing as well as systems and management.

“Our students are able to adopt practice across a variety of settings, ultimately influencing outcomes in multiple areas in the health care delivery system,” she says.

Adult-gerontology clinical nurse specialists provide advanced clinical care along with patient and staff education. They serve as consultants for complex health care problems and design evidence-based interventions. Specializations are available in cardiovascular health, oncology, critical care, complementary practice and other areas.

“Students in this track become experts in evidenced-based nursing practice, with the focus on helping people make transitions from one level of care to another,” Dr. Biddle says. “Oftentimes, their patients will have both acute and chronic health problems.”

Tara Leslie, BSN, RN, a student in this track, says that after taking a position in a cardiovascular ICU, she had her first experience working with a clinical nurse specialist—and had her first exposure to the concept of evidence-based practice.

“I quickly decided that I wanted to have a more significant impact on patient outcomes,” she says.

For the past two years, Ms. Leslie has been working with heart failure patients, and as a result, developed a special interest in assisting these populations. “I would like to direct my focus toward the comprehensive heart failure management program that integrates the newest technologies and evidence-based practices,” she says.

Ms. Leslie says she has had a very positive experience in the program. “My advisor has been very involved and has provided excellent guidance throughout the program. It has been a solid base to build my career upon.”

A pediatric nurse practitioner specializes in health care for infants, children and adolescents. They practice in a range of settings, including children’s hospitals, physicians’ offices, schools, and other acute and primary health care settings.

These advanced practice nurses educate and counsel caregivers about management of common childhood illnesses, child safety and health promotion strategies. They learn to diagnose health problems, perform physical examinations and evaluate treatments for acute and chronic health problems, focusing on everything from normal growth and development to advising children on how to manage chronic conditions.

“Students become experts in the management of common health conditions as they occur in children,” says Dr. Scott. “We go very in-depth during our training process on the growth and maturation of children and how it impacts a child’s health and wellness. That is where our training and expertise lie—in identifying the subfactors and abnormalities as they occur.”

A second-year student in this track, Andrea Jones, BSN, RN, SANE, chose pediatrics because she enjoys working with children. “Everyone has been so encouraging and has helped me through this program,” she says. “I work full time and go to school part time, and they work with my schedule, so this works for my life.”

Currently, the pediatric nurse practitioner program focuses on primary care, but that may be expanding. Treatment of children with acute care problems and care in intensive care settings requires a knowledge base and skill set that differ from that of a psychiatric nurse practitioner prepared to work in primary care. Therefore, the college’s faculty and UK HealthCare administrators have agreed to add an Acute Care Pediatric Nurse Practitioner Track to the nursing options. This track will require a pediatric nurse practitioner certification and is under development.

“I love working with children because you become a part of their lives and can have an impact on helping them grow and mature,” says Leslie Scott, PhD, PNP-BC, CNL, the Pediatric Nurse Practitioner Track coordinator. She became a certified dibuteur educator in 1989 while a BSN-prepared nurse and has been a primary care pediatric nurse practitioner since 1997.

“I’ve had one child as a patient since she was 9 months old, and she is now a senior in high school,” she says. “Watching her grow and helping her learn how to self-manage her diabetes has been very exciting.”

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Population and Organizational Systems Leadership Track

Nora Warshawsky, PhD, RN, has been a nurse for nearly 30 years in nursing management and quality management positions. Dr. Warshawsky’s current position in the College of Nursing is interim track coordinator for the Population and Organizational Systems Leadership Track of the DNP Program.

Instead of focusing on the care of individual patients, this track is concentrated on the study of populations. Students can choose to specialize in public health or executive leadership. Graduates can expect to hold leadership roles within health care organizations, health care systems, national organizations and professional organizations.

Graduates from this track define actual and emerging problems, and they design aggregate-level health interventions. They work with diverse stakeholders for inter- or intra-organizational achievement of health-related goals. They are able to design patient-centered care delivery systems or public policy-level delivery models.

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UK HealthCare is in the midst of an initiative designed to analyze, improve and track areas where the quality of nursing care makes a difference in patient outcomes. The Nursing-Sensitive Indicators Program is driven by a desire to standardize the best nursing practices at UK, improve outcomes and quantify the improvement with concrete data.

“Nursing-Sensitive Indicators provide a measurement, a ruler you might say, for tracking nursing care.”
—PAUL DEPRIEST, MD, MHCM, UK HEALTHCARE CHIEF MEDICAL OFFICER
“Nursing-Sensitive Indicators provide a measurement, a ruler you might say, for tracking nursing care,” says UK HealthCare Chief Medical Officer Paul DePriest, MD, MHCDS. “This is valuable for nurses because they can see specific complications they have some influence over that can be prevented by standardized care.”

The data gleaned through Nursing-Sensitive Indicators allows UK HealthCare to track its own progress in decreasing and eradicating these complications, as well as track the growing national push to compare the quality of care at hospitals, says Cecilia Page, MSN, RN-BC, CPHIMS, PMP, FACHE, executive director of informatics at UK, who is leading the overall program coordination, as well as the information technology aspect of the program.

“This program is fundamental to continuously improving the quality of nursing practice at UK. We baseline our current performance, compare ourselves to industry benchmarks and implement innovative nursing practice solutions to improve patient outcomes,” she says.

UK HealthCare adopted its program from the American Nurses Association’s (ANA) Nursing Quality Indicators initiative. In 1998, the ANA developed the National Database of Nursing Quality Indicators (NDNQI) so the ANA could continue to build on data from earlier studies and further develop nursing’s body of knowledge related to factors that influence the quality of nursing care. The connection between nurse staffing and patient outcomes had already been identified, but continuing data collection and reporting was needed to evaluate the quality of nursing and to fulfill nursing’s commitment to evaluating and improving patient care, according to the ANA.

NDNQI’s mission is to assist nurses in their efforts to improve patient safety and quality of care by providing national, comparative, research-based data on nursing care and the relationship of this care to patient outcomes.

Starting earlier this year and continuing through April 2012, UK HealthCare has been addressing one of these indicators each month, deploying a carefully thought-out, methodological strategy to reduce the incidence of these conditions. An additional month will be spent covering nursing staff skill mix, nursing hours per patient day, nursing turnover rate, RN certification/education and RN satisfaction. While the Nursing-Sensitive Indicators are primarily focused on the quality of nursing care impacting patient outcomes, these additional metrics evaluate the quantity of nursing provided in patient care, says Mrs. Page. They include metrics such as hours of nursing care provided for a patient, the skill mix of licensed versus non-licensed personnel providing care, and the education level of nursing personnel.

“This set of nationally recognized indicators has been identified as the best indicators of quality nursing care,” says Suzanne Prevost, PhD, RN, COI, associate dean for practice and engagement, UK College of Nursing. “They are indicators where good nursing care makes a difference.”

The implementation of each indicator starts with a selected committee that consists of not only nurses but also staff management, a nurse educator, an administrator and an expert on that indicator. The committee reviews current practices and researches the best evidence-based practice. After identifying any gaps between current and ideal best practice, a plan is designed, laying out specific nursing protocols and key interventions to use best practices based on current research. A blueprint for documentation and collection of data is developed to go along with the changes to ensure adherence and to measure progress. Next, the staff is educated about the indicator and the changes that will take place both in patient care and in documentation. The final and ongoing step is measuring and analyzing the data, including each unit keeping a scorecard, which leads to seeing what can be done to continually improve care.

“This is both a targeted program to measure outcomes and an aggressive educational campaign,” says Dr. Prevost.

The educational component includes a detailed explanation of the pathophysiology of the condition and exactly what nurses can do to influence the outcome, says Mrs. Page. This is necessary because, as part of health care changes, nurses are also being asked to take on a bigger role in patient care. These protocols will be nurse-driven. Rather than waiting to be directed by the physician, nurses will rely on their critical thinking skills and function in a more active and collaborative role. “We want to emphasize the role of nursing in patient advocacy and in clinical decision-making in the plan of care.”

The latter is a large focus on the ‘Future of Nursing’ document recently published by the Institute of Medicine and Robert Wood Johnson Foundation,” says Mrs. Page. “The desire is to promote higher levels of education by the profession of nursing thereby enhancing the quality of care and promoting optimal health outcomes.”

For example, the prolonged use of urinary catheters is correlated with a higher infection, but now it’s clinical procedure.”

Another example is the prevention of pressure ulcers, commonly known as bed sores, says she. Pressure ulcer avoidance is highly correlated with nursing actions, such as turning patients on a regular schedule and employing appropriate skin-care measures and ensuring adequate nutrition. Pressure ulcers are costly to treat and may increase the patient’s risk for infection with the need for a longer hospital stay. As part of the effort to eradicate pressure ulcers, mattresses have been replaced, but it is incumbent upon the nurses to make sure patients are turned. “We’ve built an entire protocol around clinical evidence that supports this practice.”

The methodology provides a standardized framework for the improvement actions focusing on each Nursing-Sensitive Indicator. The cycle is ongoing as innovations and improvements are incorporated into practice.
“At UK HealthCare, our goal is zero percent for pressure ulcers,” says Dr. Weaver.

UK HealthCare Patient Care Manager DeeDee McCallie, BSN, RN, CCRN, who oversees the catheter-associated urinary tract infection (CAUTI) initiative and will oversee the physical restraint initiative, says watching nurses connect the dots and form an understanding of how their actions directly impact their patients has improved their delivery of care.

“We have experienced a culture change at UK HealthCare,” Mrs. McCallie says. “There’s been a lot more individual accountability and ownership. Nurses ultimately want to do a good job. Now they know if they do A, B, C, and C, they will protect the patients from D, E, and F.”

“The Nursing-Sensitive Indicator Program has not only equipped nurses with new knowledge, but it also has enhanced their clinical skill set.”

The UK College of Nursing curriculum is also placing more focus on these indicators, starting in the students’ sophomore year, says UK College of Nursing Lecturer Jessica Wilson, MSN, RN, APRN. “Nursing students want to help people,” says Mrs. Wilson. “Job is to empower students to know they can make a difference to patient outcomes.”

Mrs. Wilson says the indicators are defined for students and examples of nurse-driven protocols at UK HealthCare are provided. Classroom, lab instruction and clinicals also provide hands-on opportunities to put them into practice. For instance, as part of a lab, a simulated patient scenario known as “the little room of errors” is set up like a hospital room, with a mannequin in the bed, and students have to go through and identify known as “the little room of errors” is set up like a hospital room, with a mannequin in the bed, and students have to go through and identify the places they can intervene to ensure the safety of the patient, such as putting up the side rails, making sure medication isn’t left lying around and checking the “patient” for pressure ulcers. During clinicals, nursing students will also go into a real patient’s room and assess the environment for the potential for errors.

“Many of our faculty connect the dots and form an understanding of how their actions directly impact their patients,” Mrs. Wilson.

In the last semester of their senior year, nursing students do a clinical rotation, working 36 hours a week with a practicing nurse, says Darlene Welsh, PhD, RN, assistant professor, UK College of Nursing. During the rotation, the rotation, they are asked to submit a log where they look at Nursing-Sensitive Indicators data from their particular unit. They have to tell us about how the Nursing-Sensitive Indicators are being tracked, the protocols being used to prevent negative outcomes, the interventions being taken and the data being gathered,” says Dr. Welsh. “They have to give us recommendations on how they would improve practice. They are taking what they learned in the classroom and applying it.”

Dr. Welsh says this assignment helps nursing students envision themselves in the role of a professional nurse. “They are not just doing tasks; they are seeing the whole picture and what they can do to improve it.” She says UK HealthCare Chief Nurse Executive Colleen Swartz, DNP MBA, RN, NEA-BC, says that the Nursing-Sensitive Indicators focus attention on the importance of day-in and day-out nursing. “These indicators are very sensitive to the conduct of nursing care,” she says. “They are our contribution to the care model and they show the things nurses do that make a difference.”

The challenge UK HealthCare faces over most hospitals in the state and region is that it resides in the top 10 percent nationally in patient acuity levels, even when compared with other academic medical centers. UK HealthCare comprises UK Good Samaritan Hospital, UK Albert B. Chandler Hospital and Kentucky Children’s Hospital. Within the latter two facilities are trauma, cancer and transplant centers, a congenital heart program, and a Neonatal Intensive Care Unit, all of which drive the most acute patients from surrounding hospitals that usually aren’t equipped to handle such cases. “We have to have very high standards,” Dr. Swartz says. “Our responsibility is to be a resource and provide nursing care for all these complex cases. We have to be about quality, safety and service. We need exemplary outcomes.”

The more ill the patient, the more important it is to follow evidence-derived standard treatment protocols, says Dr. DePreist. Any of the conditions related to Nursing-Sensitive Indicators can be devastating to someone whose health is already severely compromised. “At UK HealthCare we have to provide the best care 24/7,” he says. “We employ the most highly trained and specialized nurses in the profession, and it behooves us to track their superb performance with Nursing-Sensitive Indicators.”

The reason for implementing one indicator each month rather than all at once is to give nurses the opportunity to digest the information and integrate changes into their practice. “We’ve given ourselves enough time to be scientific and make the steps are imbedded in practice,” Dr. Swartz says. Part of embedding the protocols in practice is also teaching proper documentation and improving the quality of documentation in medical records.

“We have to be able to track the data,” says UK HealthCare Nursing Quality Improvement Coordinator Jill Blake, MSN, RN. “A big part of this is making sure we capture what we need and get it into the system.”

Managing that process includes incorporating and measuring data along every step, from providing quality care predicated upon evidence of best practice, to documenting the care provided, then managing the data in a way to produce information and feedback to the care providers (benchmarking).

“We needed to benchmark ourselves, so we switched to NDNQI, where we can submit the data and compare our performance with other like organizations,” says Mrs. Blake.

Another critical success factor has been using software capabilities to drive standardization by hardwiring the electronic documentation practices into the nurses’ routines, says Mrs. Page. What helps is that the documentation systems have been programmed to remind and alert nurses when something has been overlooked.

“We are doing better nursing practice with the utilization of technology,” she says.

With the data collected, UK HealthCare will be able to chart its own progress— including comparing units within the medical center—as well as determining how the data compares to other hospitals and academic medical centers. The overall goal is to continue to improve care processes, she says.

Jeff Norton, co-director for the Center for Enterprise Quality and Safety at UK HealthCare, says there’s a whole alphabet soup of agencies and organizations that are trying to measure safety and quality at hospitals and that it’s a Herculean task to rank and compare them in a manner that makes sense. “We are driving better nursing practice with the utilization of technology,” she says.

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The baby looks like any other newborn you would find in the hospital nursery: a normally sized, full-term baby with soft skin, downy hair and that newborn smell. Except this baby is profoundly unhappy. She arches and screams inconsolably. She sucks frantically yet feeds poorly. She sweats, breathes rapidly, sneezes, yawns, and grows lethargic before starting another round of high-pitched, desperate screaming. Her little limbs move so frantically that the soft skin on her face and elbows is rubbing off, and she has a horrible diaper rash from constant diarrhea.

Over the past five years, there has been a dramatic increase in the number of infants treated at Kentucky Children’s Hospital suffering from neonatal abstinence syndrome (NAS), in which babies are born addicted to the same drugs their mothers were taking while pregnant, and begin feeling the effects of withdrawal the moment the umbilical cord is cut. Kentucky Children’s Hospital handles many of the most acute cases in the central and southeastern regions of Kentucky with as many as two-thirds of their NAS population transferring from outside hospitals.

“Over the last year or so anywhere from 10 to 15 percent of our NICU (Neonatal Intensive Care Unit) patients have been here for neonatal abstinence syndrome,” says Lori Shook, MD, professor of pediatrics with the UK College of Medicine and a neonatologist with the children’s hospital. “And that’s their primary diagnosis, meaning that’s what they were admitted for.”

As the population of NAS patients in the NICU increased, it became apparent that a formal protocol focusing on the unique needs of NAS babies needed to be developed.

“Everyone had their own opinion on how to take care of these babies,” says Dr. Shook. “One person would do it one way, and two days later someone would come along and change it. We didn’t have a cohesive goal, and babies were just here too long. And now, as we say in the horse world, we’re all pulling the same way in the harness.”

Assembling the “Pit Crew”

With Dr. Shook in the lead, Kentucky Children’s Hospital approached the challenge with a unique multidisciplinary Neonatal Abstinence Task Force that sought to combine the best in chemical and developmental care to most effectively and comfortably wean NAS babies off their drug addiction.

The team design of the Neonatal Abstinence Task Force is a microcosm of a growing national conversation regarding changes needed in the health care industry to handle a diverse patient population, combined with the increased number of specializations within the medical community. This issue was most recently highlighted at the 2011 Harvard University Medical School commencement address, delivered by Atul Gawande, MD, associate professor of surgery at Harvard Medical School and associate professor with the Harvard School of Public Health, who argued in his address, “We train, hire and pay doctors to be cowboys. But it’s pit crews that people need.”

This is precisely the approach the children’s hospital NICU is taking to deliver the best care possible to its NAS population.

“Over the last year or so anywhere from 10 to 15 percent of our NICU (Neonatal Intensive Care Unit) patients have been here for neonatal abstinence syndrome,” says Lori Shook, MD, professor of pediatrics with the UK College of Medicine and a neonatologist with the children’s hospital. “And that’s their primary diagnosis, meaning that’s what they were admitted for.”

The baby looks like any other newborn you would find in the hospital nursery: a normally sized, full-term baby with soft skin, downy hair and that newborn smell. Except this baby is profoundly unhappy. She arches and screams inconsolably. She sucks frantically yet feeds poorly. She sweats, breathes rapidly, sneezes, yawns, and grows lethargic before starting another round of high-pitched, desperate screaming. Her little limbs move so frantically that the soft skin on her face and elbows is rubbing off, and she has a horrible diaper rash from constant diarrhea.

Over the past five years, there has been a dramatic increase in the number of infants treated at Kentucky Children’s Hospital suffering from neonatal abstinence syndrome (NAS), in which babies are born addicted to the same drugs their mothers were taking while pregnant, and begin feeling the effects of withdrawal the moment the umbilical cord is cut. Kentucky Children’s Hospital handles many of the most acute cases in the central and southeastern regions of Kentucky with as many as two-thirds of their NAS population transferring from outside hospitals.

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As the population of NAS patients in the NICU increased, it became apparent that a formal protocol focusing on the unique needs of NAS babies needed to be developed.

“Everyone had their own opinion on how to take care of these babies,” says Dr. Shook. “One person would do it one way, and two days later someone would come along and change it. We didn’t have a cohesive goal, and babies were just here too long. And now, as we say in the horse world, we’re all pulling the same way in the harness.”

Assembling the “Pit Crew”

With Dr. Shook in the lead, Kentucky Children’s Hospital approached the challenge with a unique multidisciplinary Neonatal Abstinence Task Force that sought to combine the best in chemical and developmental care to most effectively and comfortably wean NAS babies off their drug addiction.

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This is precisely the approach the children’s hospital NICU is taking to deliver the best care possible to its NAS population.

“We brought a group of health care professionals together representing nine different disciplines, including a pediatric pharmacist, occupational therapist and advanced practice professionals to develop a more standardized approach to neonatal abstinence syndrome patients,” says Chief Nurse Executive Colleen Swartz, DNP, MBA, RN, NEA-BC, UK HealthCare. “Before these was a lot of variability in their care, and now, as a result of this collaboration, we have a consistent approach and are seeing a dramatic improvement in outcomes for these babies.”

And it all starts with the NICU nurses.

Nurses Key in Protocol Development

After the establishment of the Neonatal Abstinence Task Force, a group of its members visited Thomas Jefferson University Hospital in Philadelphia, one of the longest-standing neonatal drug treatment programs in the country, to study its techniques, which would help guide the development of new protocols at Kentucky Children’s Hospital affecting NAS patients. NICU Patient Care Manager Kathy Isaacs, MSN, RN, RNC-NIC, believes that this opportunity to observe both the nursing and provider aspect of NAS patient care in action at Thomas Jefferson University Hospital helped tremendously in developing a multidisciplinary protocol for the NAS patient population.

“The visit helped us envision the whole treatment picture, to give it a voice and move it through on a much bigger volume than just one discipline. This was the opportunity to observe both the nursing and provider aspect of NAS patient care in action at Thomas Jefferson University Hospital helped tremendously in developing a multidisciplinary protocol for the NAS patient population.

“The visit helped us envision the whole treatment picture, to give it a voice and move it through on a much bigger volume than just one discipline.
Donna Wood, LPN, uses a Spring motion to soothe NAS babies. This motion is more comforting to NAS babies than a more traditional sway with front-back motion. Ms. Wood is one of the NAS Nurse Champions.

Patient Care Manager Assistant Kara Shreve, MA, BSN, RN, was part of the group that visited Thomas Jefferson University Hospital and after returning to Lexington sent out an email asking for volunteers from the NICU nursing staff to see if anyone was interested in helping to develop a rapid response protocol for NAS infants.

“I ended up getting a response with the greatest blend of seasoned nurses and new nurses combined,” Ms. Shreve says. “This project has really allowed those different generations of nurses to work together strongly. We call them our NAS Nurse Champions.”

The nurses at the bedside are the first to identify NAS babies using a quantitative scale developed in the 1960s and 1970s by Loretta Finnegan, MD. The Finnegan Scale measures the severity of various NAS symptoms such as sleep patterns, Moro reflex, smiling, tremors, vomiting and loose stools. The score provides the brain for the baby’s chemical treatment.

Starting with a standard dose of 0.4mg/kg/day of morphine, divided among feedings, NAS babies are scored every six hours and their morphine increased until their symptoms are lessened enough for them to be comforted.

“We go for scores of less than eight out of a possible score of 10 because that tells us the baby is having minimal withdrawal symptoms,” Dr. Shook explains. “When you reduce the score anywhere less than eight, you let the baby sit for a while, get itself together, feed and grow for a few days, and then you see the down-spiral process.”

Using rapid cycle changes in protocol has allowed Dr. Shook and task force members to improve protocols for these infants, accelerating their ability to begin weaning them off their medication.

And they rely heavily on feedback from the nursing staff regarding what is and is not working.

“This is an ongoing and evolving treatment plan,” says Ms. Shreve. “The role nurse has played in the NAS protocol development. “Everyone on the team get the opportunity to come to the table, so we all get an opinion on where we need to be going with things. The nurses have a very good gauge on what is working and not working. I think we’ve been able to create a supportive environment in which the nurses feel they can communicate their observations openly so we can take care of any issues immediately rather than waiting for a big problem to develop.”

Ms. Shreve recounts how in the early stages of protocol development, they started by following the protocol used at Thomas Jefferson University Hospital, which gives NAS babies therapeutic doses of morphine every six hours. “When that didn’t work, the nurses let us know, and we were able to change that to what it is now—every three to four hours,” Ms. Shreve explains.

In addition to providing valuable feedback on protocol development, including how often scoring should take place and the frequency of dosages, the NAS Nurse Champions of the NICU are uniquely positioned to advise and administer non-chemical soothing techniques to this patient population.

One of the first recommendations by the NAS Nurse Champions was to move the NAS infants, as soon as they were identified and their withdrawal symptoms under control, from the fast-paced, brightly lit nurseries on the fourth floor NICU to the less stimulating environment of the third floor NICU.

After a few hours at a high-energy concert, full of light and sound and people and activity, the average adult can become completely over-stimulated. “NAS babies have that to the hundredth degree because of their drug addiction,” says Ms. Shreve. “It’s just like a withdrawal that an adult would endure except they can’t communicate what’s happening to them.”

Under the old protocol, NAS babies would be admitted into any NICU nursery that it made sense to put them at the time. Often this wasn’t good for either the NAS babies or other babies in the NICU population. Certain NICU infants cannot tolerate being next to a screaming, crying, withdrawal baby, and conversely the hyping, lights and activity of the fourth floor NICU environment would agitate the NAS babies even more than they already are.

“They cannot tolerate any extra stimulation, especially early on,” Ms. Shreve explains. “The nursery of the third floor NICU traditionally hold patients who are stabilized and just waiting to grow large enough to head home. The environment is much quieter and home-like than the fourth floor NICU and gives NAS babies the less-stimulating environment they need, especially at the beginning of their treatment. Given their symptoms, infants suffering from NAS are particularly fragile and require a great deal of extra attention, and their care can take a huge emotional toll on the nursing staff. The standard of care in the NICU setting calls for a maximum 3-to-1 patient-nurse ratio, and the new protocol calls for only one of those patients being a baby suffering from NAS.”

“Nurse burnout is also a big problem,” Ms. Shreve adds. “This is an ongoing and evolving treatment plan.”

The NICU nurses, including some of those specializing in NAS infants, took part in Certified Infant Manage Nurse training, a proposal that was developed directly from the NAS protocol initiative.

“We read more and more about managing therapies with small babies, and a number of the staff thought it might be a good thing for the drug babies,” says Ms. Broaddus, a 40-year veteran in the NICU. “Sometimes you just can’t find something that is calming to them. Sometimes anything that causes stimulation is just way too much. But we had evidence that this type of therapy would allow them to calm in their behavior.”

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Some of them like the swing. Some of them like different things," says NAS Nurse Champion Brittany VanDeCar, BSN, RN.

"Different babies like different things," says NAS Nurse Champion Vanity VanDeCar, BSN, RN. "Some of them like the swing. Some of them like to sleep only in their bed. You just get to know the baby and get to know their little quirks and what works for them." In addition to providing personal comfort to these suffering babies, NAS nurses are often in a position to ease the transition between NICU and home. Particularly for the mothers of these infants who are themselves going through major life changes and drug treatments that are very difficult, Ms. Isaacs hopes that being able to share comfort techniques with the recovering mother will help with mother and baby bonding and developing mothers’ confidence in their ability to comfort their babies. By working with a baby consistently gives the maternal bond with that baby or how you can facilitate that baby going to foster care and getting them ready to go home.

"The less time in the nursery, for the baby, the better," Dr. Shook says. "Babies aren’t supposed to grow up in a nursery; they are supposed to grow up in a home. And the nursing staff are the linchpins in caring for these babies and getting them ready to go home."
Over the last two decades, the number of men joining the nursing profession has dramatically increased. Even so, according to the 2011 report by the Institute of Medicine, “The Future of Nursing: Leading Change, Advancing Health,” males still only make up 7 percent of the RN workforce. A piece of good news: At the University of Kentucky’s College of Nursing, the enrollment of men has doubled in the past 10 years, growing from 6 percent in 2001 to 12 percent in 2011. Dean Jane Kirschling, DNS, RN, FAAN, UK College of Nursing, says she is pleased with the increase and hopes to see the number of men choosing a nursing career continue to rise, particularly as the demand for nurses keeps growing. By 2020, nursing shortage projections range from a quarter million to a half million as baby boomers age, live longer and expect better health care.

“The reality is that nursing is a predominantly female discipline,” she says. “We are making a concerted effort to diversify, with both males and minorities, and a very important part of the mix is making sure we meet the need for nurses.”

Choosing Nursing

The reasons men get into nursing are as varied as the reasons women get into nursing, but few men grew up thinking they would become nurses. For many male nurses, particularly ones who have been in the profession several years, it wasn’t even on their radar when they entered college.

Terry Lennie, PhD, RN, FAHA, FAAN, who is associate dean for PhD studies at UK’s College of Nursing, says he headed off to college nearly three decades ago planning on studying computer programming. “Nursing was not commonly considered a career option for men back then.” To help pay for his schooling, he worked in a nursing home because the hours fit around his school schedule. One of his co-workers, a nursing assistant, told him how good he was with the residents and suggested he go into nursing. Dr. Lennie took the woman up on her advice and changed his major. As he progressed through school, the scenario repeated itself twice. As an undergraduate, he was prompted by a nurse to go on and get his master’s degree, and then as a graduate student, a professor recognized Dr. Lennie would make a good researcher and educator and encouraged him to get his doctorate. He did, becoming the first male doctoral student at the University of Wisconsin’s School of Nursing. “I happened upon nursing but have never regretted choosing it as my career,” he says. “Every day brings something different, a new challenge.”

Dr. Lennie says he’d like to see more men seek advanced nursing degrees, pursuing opportunities in academia, where they can become role models for the next generation.
Khay Douangdara
BSN, RN
At Chandler Hospital, nursing always had been an option. Mr. Proud, who graduated from UK in 2002, wanted to do something in the health care field and figured out early on that medical school was off the table because of the length of the obligation. An aptitude test he’d taken indicated nursing or teaching would be a good fit, and already interested in medical care, he decided to do something in the health care field and figured out that UK also pays for advanced nursing degree programs, making it more appealing,” he says, adding that UK also pays for advanced nursing degree programs, making it more appealing. But Mr. Proud does acknowledge differences but Mr. Proud also says it is not a male-female thing. "Actually, embrace your difference! Men and women both need each other because you need both men and women to have a healthy, balanced lifestyle. It’s important to have both men and women in the same field. But men and women also need to support each other in whatever field they choose. And we need to respect each other. You can help them when they are in crisis and in pain, you can also make them smile or laugh. That’s what I like to do. Being able to help people. It’s rewarding," he says. "Especially those days when you know you’ve made a difference." 2 ERIC AFUSEH
BSN, BS, RN
When it comes to being a male in a predominantly female profession, men in nursing want other men to realize it’s not an issue. "My advice would be: You are going to be nurses, not male nurses," says Mr. Pang, an OB nurse. "Men can be great nurses. Present yourself professionally. Give your patients a good first impression, as if it were your last chance to impress them. Incorporate your own philosophy into your patient care. Be you and don’t be afraid to be different. Actually embrace your difference!” Mr. Pang also says it is not a male-female thing. "It’s about taking care of people," he says. "You have to have that instinct. You can always help people, but you also have to help people through the process. The basis of nursing is taking care of people." But Mr. Pang does acknowledge differences between the sexes. "You can generalize, but there’s definitely a different feel when there’s an all-female staff. "It’s a sexist comment, there’s just a different dynamic when both men and women are present." Many men seem to gravitate toward the faster-paced, higher tech, more autonomous fields of nursing such as in the emergency treatment division, tumor policy research, and the intensive care unit. But the hospital, that can be found all over. The nursing field is vast and there is something for everyone. "Men often want situations where they can make decisions and act quickly. But now, given the higher patient acuity throughout the hospital, that can be found all over. Men sometimes bring different approaches to things," says Dr. Lennie. "Men have a lot to offer the nursing profession. There’s a place for them when it comes to caring for patients and advancing the profession. Nursing is high tech and high touch. Men and women provide both aspects equally well." 3 CHUN (JERRY) PANG
BSN, RN
Chun (Jerry) Pang, BSN, RN, who playsfully refers to himself as the best male OR nurse at Chandler Hospital, says he did not plan at all to go into nursing. "My original plan was to be a pharmacist and that was the reason why I come to Lexington," he says. "I applied to the pharmacy school and went through a two-day interview but was not accepted after all. Then a friend of mine who was a nurse suggested I try nursing. So I applied and I got in the last minute… Not getting into the pharmacy school was probably one of the best things that ever happened to me. I’ve come to realize that a pharmacist can prepare and dispense the best drug to treat a patient’s condition but seeing her getting better at the bedside means more to me." 4 MATTHEW PROUD
BSN, RN
For younger nurses, like Matthew Proud, BSN, RN, patient care manager in the Adult Emergency Center at Chandler Hospital, nursing always had been an option. Mr. Proud, who graduated from UK in 2002, wanted to do something in the health care field and figured out early on that medical school was off the table because of the length of the obligation. An aptitude test he’d taken indicated nursing or teaching would be a good fit, and already interested in medical care, he decided to go into nursing as a career. "Nursing absolutely has been a good fit," he says. "I don’t know what I’d be doing if I weren’t doing this." 5 JAMES GRAU
BSN Nursing Student
UK nursing student James Grau started college knowing exactly what he wanted to do. "My grandmother and aunt were nurses, and I had been looking into it for a while. It was just a question of fine-tuning my vision," says Mr. Grau, who plans to pursue his CRNA. "This is my chance to give back to people and impact their lives." 6 GREG CASADA
MSN, RN, nurse recruiter at UK, says the stigma of being a man in nursing is starting to wear off. New entrants into the field often think of the stereotype that men are not as compassionate or as caring. But Mr. Casada says he wants to go on and become an American citizen. In Cameroon, he worked in an intensive care unit at UK for almost three years now. Mr. Afuseh says that coming to the United States was a turning point in his life over. Now enrolled in the College of Nursing’s BSN-DNP Option, his goal is to work with people in the area of addiction. "I've come to realize what they can do to help people," he says. "I've come to realize what they can do to help people," he says. 7 CHIZIMUZO T.C. "ZIM" OKOLI
PhD, MPH, RN, College of Nursing, is a third-generation nurse, starting with his grandfather, who was an army nurse in Nigeria, and continuing with his mother and now him. "She asked me to think about nursing, and I did," he says. "I decided I liked its holistic approach." A thinker by nature, Dr. Okoli also took philosophy courses, obtaining a double undergraduate major, then going on to get master’s degrees in nursing and public health (all from UK), which led to working at Eastern State Hospital for a year. Then, he became involved in not just nursing patients but also in changing approaches to treatment. He went back to school and topped his education off with a doctorate in nursing, again from UK. His love of research and learning led him into education at UK, where he now is an assistant professor and director of the Tobacco Prevention and Treatment Division, Tobacco Policy Research Program. The continuous educational opportunities in nursing that have been vital. Dr. Okoli says, in meeting his boundless curiosity. "A good nurse is one who is not satisfied with the status quo and wants to learn and improve their practice," he says. 8 BRIAN ELY
MSN, RN, CRNA, chief nurse anesthetist at Chandler Hospital, says he eventually became a nurse anesthetist because it fit his self-described type-A personality. "Nurse anesthetists are a certain breed," he says. "They are very autonomous, high-strung and perfection-oriented." Mr. Ely, who spent seven years working in the ICU at Chandler, says during his 20-year career he has always been given the higher patient acuity throughout the hospital, that can be found all over. The nursing field is vast and there is something for everyone. "Men often want situations where they can make decisions and act quickly. But now, given the higher patient acuity throughout the hospital, that can be found all over. Men sometimes bring different approaches to things," says Dr. Lennie. "Men have a lot to offer the nursing profession. There’s a place for them when it comes to caring for patients and advancing the profession. Nursing is high tech and high touch. Men and women provide both aspects equally well." 9 KHAY DOUANGDARA
BSN, RN, PhD
Khay Douangdara, BSN, RN, an emergency room nurse at Chandler Hospital who is working on his MSN, became a nurse. "I love interacting with patients," he says. "You can help them when they are in crisis and in pain, you can also make them smile or laugh. That’s a rewarding thing for me." Mr. Douangdara says he wants to go on and teach at the college level so that he can share what he’s learned. "I want to help people realize what they can do to help people," he says. "It’s scary being a new nurse, and I want to help them be confident in what they do." "I applied to the pharmacy school and went through a two-day interview but was not accepted after all. Then a friend of mine who was a nurse suggested I try nursing. So I applied and I got in the last minute… Not getting into the pharmacy school was probably one of the best things that ever happened to me. I’ve come to realize that a pharmacist can prepare and dispense the best drug to treat my patient’s condition but seeing her getting better at the bedside means more to me." "UK HealthCare offers the whole package," he says. While the whole package is big plus, what many men seem to appreciate most are the endless career options, educational opportunities and potential for advancement in nursing that allow them to find just the right fit.
In 1994, Dr. Patricia Benner published a landmark study called, “From Novice to Expert: Excellence and Power in Clinical Nursing Practice.” In the words of classical work, Dr. Benner applied the Delphi Model of Skill Acquisition in nursing practice to identify the five stages of development nurses undergo on their journey from novice to expert. In 2010, the College of Nursing and UK HealthCare were among the pilot sites that developed the pioneering BSN Residency, based in part on recommendations and findings associated with Dr. Benner’s work. The BSN Residency Program is a mandatory one-year orientation and support program for new baccalaureate nursing graduates employed as staff nurses on clinical units at UK HealthCare. The program was designed to help them make the transition into practice through education, hands-on learning, peer support and group projects. To date, approximately 750 nurses at UK HealthCare have gone through the BSN Residency. Shyanne Stratton, BSN, RN, manager of nurse recruitment, UK HealthCare, calls the BSN Residency “a powerful recruitment tool for UK HealthCare hospitals, enabling the residency program with sweeping the average first-year BSN new graduate turnover rate at just 10 percent, significantly lower than the national average of 27 percent.

Every first-year nurse at UK HealthCare participates in the mandatory one-year BSN Residency Program. Novice nurses from similar units are placed together in small groups for education, support and projects to help them as they transition into practice. Ms. Byrd was asked for a word to describe her experience so far as an ICU nurse. She thinks a moment before answering. “Whew,” she says. “The word is definitely ‘whew.’”

There are exceptions to every rule and recent UK College of Nursing Graduate Kaitlyn Keinath, BSN, RN, is one of them. For the irrepressible Ms. Keinath, that nagging feeling in the pit of her stomach isn’t worry about getting a difficult assignment. It’s worry that she won’t get one today.

When we first talked to Ms. Keinath, she was still in orientation as a new surgical ICU nurse at Chandler. A few weeks earlier, she’d begged to be allowed to take care of a cardiac patient whose heart had flown in for emergency surgery. “I really, really wanted an admit because they’re scary and when you’re in orientation you might be the first nurse they’ve flown in for emergency surgery. I really wanted an admit because they’re scary and when you’re in orientation you might be the first nurse they’ve flown in for emergency surgery.”

Ms. Keinath had worked as a nursing care technician at a nearby community hospital all through school and loved it so much she ended up working almost full time, though her nursing professors discouraged it. “I couldn’t stay away,” she says. “I’m good at it.” She points to her recent assignment as an example.

Erin Byrd, BSN, RN, “wasn’t getting a response. The patient, an elderly man in UK Albert B. Chandler Hospital’s Clinical Decision Unit (CDU), wasn’t reacting to any of the usual cues. Ms. Byrd, a first-year nurse and recent graduate of the UK College of Nursing, was barely halfway through her 14-week orientation at the hospital and making rounds on her own for the first time. (The Clinical Decision Unit is a 24-bed transitional unit, providing care to patients at all levels. It serves primarily to begin the inpatient care of patients admitted from the Emergency Department and to facilitate swift acceptance and evaluation of interfacility transfers.)”

Her nurse preceptor during orientation, always nearby, was able to step in. “I’m decent on hating so fast!” says Ms. Byrd in an interview early last spring. In what seemed like seconds, she says, the room was alive with physicians, she remembers administering an IV under her nurse preceptor’s watchful eye, her own heart pounding. “I kept thinking, ‘What if this had happened at UK HealthCare, and you have to be able to think on your feet,’” says Ms. Byrd’s nurse manager, Jamie Cross, BSN, RN, patient care manager. “You never know what the day will bring, says Ms. Byrd, who still carries her high accout textbook from nursing school around with her but administers a standard of decision making that’s never a chance to look at it.”

In school, there’s time to study and really think about what you’re learning. Here, there isn’t. You need to act and make decisions and sometimes really fast.”

Experts in nurse development say time management is often a challenge for the first-year nurse. Ms. Byrd believes it. “Just trying to figure out what to do next is complicated.” She says her nurse manager, Jamie Cross, BSN, RN, patient care manager, “It’s good to see you.”

And her preceptor — what did she do? “She did was look at her preceptor in astonishment. ‘Whoa,’ she says. ‘The word is whoa. ’”

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Once in the ICU, the recuperating cardiac patient was doing very well, she says, until an increasingly irregular heart rate began defying all attempts to control it. As physicians worked to regulate the patient’s heart rate, Ms. Keinath, her sense on high alert, remembers a cardiac protocol she observed from her days working as a technician. “It called for a drug we don’t typically use, but I mentioned it to the team anyway,” says Ms. Keinath. She remembers holding her breath, afraid she’d blown it. “But the doctor said, ‘wonderful idea,’ and asked me to do it as fast as possible. The best part, says Ms. Keinath, was that the protocol worked and the patient was successfully stabilized. “I made a good clinical decision and I had backup, she says. “I wouldn’t go so far as to say that I earned my wings that day — but I think I earned some trust. It was a really good feeling. I love this job; I really do.”

Jan Davis, BSN, RN, now patient care manager for Trauma Surgical Tower 101 in the new Chandler pavilion, was Ms. Keinath’s first nurse manager before the unit’s move to the new hospital. She remembers interviewing Ms. Keinath for the job and the enthusiasm she showed. “She knew what she wanted,” says Ms. Davis, who believes many ICU nurses share a similar passion for the action and thrive on the energy and adrenaline it produces. But despite her confidence and clinical experiences, which included a SNAP externship in Medicine ICU at Chandler the summer before, Ms. Keinath was still a novice nurse and reminders of that were everywhere. For example, just a few days earlier, she’d paged a doctor to the ICU who, as it turned out, was already there working with someone else.

**AFTER THREE MONTHS IN ACUTE CARE AT KENTUCKY CHILDREN’S HOSPITAL, THE PROBLEMS FOR ANDY STEEDLY, BSN, RN, IS HIS SLEEP SCHEDULE.** The new BSN graduate has been working alternating day and night shifts since coming on board in January and has now exclusively assigned to nights. So how was he adjusting to a day that begins at 7 p.m.? “I’m still figuring that one out,” he admits in our first interview last March, adding that some of the older, more experienced nurses will tell him to stick to the same schedule every night. “He’s trying.”

He’s also trying to adjust to the idea that at age 23 and a brand-new nurse, he’s looked to as an authority. Anxious parent and grandparents are depending on him for answers. “If they ask a question and I don’t know, I’ll say, ‘I don’t know, but let me go ask somebody that might know,’” Mr. Steedly’s past clinical experiences have proven valuable, he says. His three years in adult medical/surgical at Chandler as a nursing care technician and, later, as a SNAP extern have always wanted to work in pediatric care, though, and was able to do so during his three years at Kentucky Children’s Hospital. Thanks to the 220 practice hours it gave him, he was able to sail through his new nurse orientation in just five weeks.

Lisa Butcher, BSN, RN, patient care manager for acute care, Kentucky Children’s Hospital, is Mr. Steedly’s nurse manager. She says there are quite a few more nurses working in acute care at the hospital. “The kids really respond to the man, particularly the older kids,” she says. 

All in all, Mr. Steedly reports, his first three months as a nurse have gone very well. While he’s not thrilled about being up all night, he loves going to work. “I look at my watch and think, it’s 3 a.m.? Really?”

Ms. Butcher says Mr. Steedly’s confidence and comfort level are right on track. “Andy is eager to learn and has it in well with the people on his unit,” she says. “He calls him an ‘all-around great person’ and laughs remembering Halloween a year ago when he was a BSN student doing his Synapse experience at the hospital. “He and Laniyke Mr. Steedly came to work that day dressed as Woody,” she says. “He loved being a cowboy character from the movies ‘Toy Story.’ A young patient, just 4 years old, was standing in the hallway when he noticed ‘Woody’s’ favorite character, walking toward him. “The little boy was overwhelmed,” says Ms. Butcher. “He just stood there in the hall, tears streaming down his face he was so happy. It was perfect.”

**BY LATE SUMMER, ALL THREE FIRST-YEAR NURSES WERE EXCITED, EXHAUSTED AND EXPECTANT, THEY WERE ALSO EXHAUSTED.** The new pavilion at Chandler had opened a few months earlier and Mr. Steedly’s unit had been busy moving patients, pumps, monitors, beds — everything — up elevators and down hallways to the seventh floor of the new building. “It was beautiful place, very aesthetically pleasing,” says Ms. Keinath, who notes that the old unit wasn’t anything but. “It was like being in large custodial closet with just curtains and floor toppers to designate which rooms were which.”

Still, she says, it gave the unit a closeness and camaraderie she hoped they wouldn’t lose. “Sure, we were hiring elves with our neighbors, but we were also in tight in a good way. We were like this little family. Everyone looked out for each other because you could see who needed help and could visualize what people were struggling with, you know?”

For Mr. Byrd, big changes were on the horizon, too. Her own unit would be dividing in early September and later that same month, she was leaving for Florida to be in a wedding — her own. “Life is busy right now,” says Mr. Byrd, though the stress she’d been feeling about working without a prescriber and making decisions on her own was gone. “I’m much more confident than I thought I would be,” she says. “We’re really a team here, and everyone’s willing to help each other out.”

As for Mr. Steedly, he was still on 4-East at Kentucky Children’s Hospital when summer rolled around but had volunteered to work in the hospital’s new pediatric progressive care unit, where the children areicker and the technology more advanced. “Working with patients at this level is a challenge,” he says, “but I like that about it.”

Mr. Steedly has also volunteered for a 12-week pilot program that would give him work on an ICU. “You could choose days or nights but since I’m still the low man on the team pole, I ended up with nights. Weekends off will be nice, though.”

Mr. Steedly may be low on the team pole in seniority, but he appears to be high in the estimation of his colleagues and superiors. “Mr. Steedly is a new nurse who has already earned his wings,” says Ms. Butcher. “He just stood there in the hall, tears streaming down his face he was so happy. It was completely unexpected and really, really nice.”

**IN A FINAL INTERVIEW AT THE END OF HER FIRST YEAR, Ms. Keinath talks about her future. She says she’s definitely going back to pursue her DNP and become an acute care nurse practitioner. “As much as I’m stuckeded to say it, I miss school a little bit,” she says. “I had some really great professors at UK. So many of them are involved in evidence-based practice and nursing theory and are just so vibrant when they speak about nursing.”**

Brenda Holm, BSN, RN, patient care manager for trauma/surgical services at Chandler, is Mr. Steedly’s new nurse manager. She says Ms. Keinath would make a good nurse preceptor someday. “He could make any part of who she is,” says Ms. Holm. “If we get something different or interesting it’s one of those nurses who can’t wait to check it out.”

Mr. Steedly says he’ll eventually pursue an advanced nursing degree, too, and thinks he might want to teach and become a clinical instructor in the pediatric unit someday. Ms. Byrd, now Mrs. Jacobs, has grown as a nurse and is an important, well-liked member of the team, says her nurse manager. Ms. Byrd says she’ll likely continue her education though she’s not sure when. What she does know is that high acuity nursing is in her blood. “She would choose this now to sum up her first year of nursing! ‘Ah-ha,” says Ms. Byrd without hesitation. And her high acuity textbook — she’s still carrying that around? “No,” she laughs. “But it is in my cat.”

In this picture is the cover of Care at Kentucky Children's Hospital. It was completely unexpected and really, really nice.
In November 2011, Dorothy Brockopp, PhD, RN, and Diana Weaver, PhD, RN, FAAN, were recognized for their exceptional contributions to nursing at Sigma Theta Tau International’s 41st Biennial Convention in Grantville, Texas.

In addition, Suzanne Prevost, PhD, RN, COI, began her term as the 29th president of the Homey Society of Nursing, STTI. Prevost will lead the 125,000-member, global organization for the next two years and will call on members to “Give Back to Move Forward” with technology. Prevost, in her Presidential Call to Action, explained, “Through global collaboration, we can bridge the gap between research and practice, share our wisdom across generations and join forces with like-minded organizations to address critical health care issues to populations around the world.”

The University of Kentucky’s Daeha Pi Chapter was also recognized when it received, for the third time, the 2011 Chapter Key Award.

Suzanne Prevost, Becomes President of Sigma Theta Tau International

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Of all the historic changes in health care over the last half century, we'd like to recognize one thing that hasn't changed: our commitment to nursing excellence and our belief in its power to make a difference in the lives of those we serve, especially here in Kentucky. To our PhD and DNP alumni and current students, our faculty and staff, and our colleagues at UK HealthCare, our thanks for proving, year after year, that partnership and collaboration are still the most powerful tools in health care.

Celebrating 25 years of PhD education, with the first students admitted in 1987 and 10 years of DNP education, with the first students admitted in 2001. We'll graduate the 100th PhD student (academic regalia hood is navy) and 50th DNP student (hood is apricot) in May 2012.
“We employ the most highly trained and specialized nurses in the profession, and it behooves us to track their superb performance with Nursing-Sensitive Indicators.”

—Paul DePriest, MD, MHCM, UK HealthCare Chief Medical Officer