VIOLENCE AGAINST NURSES
#EndNurseAbuse
The Kansas Nurse
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The purpose of The Kansas Nurse, the official publication of Kansas State Nurses Association, is to disseminate information regarding policies, positions and activities of the association and to provide a forum for discussion of nursing issues relevant to its members.

The Kansas Nurse attempts to select authors who are knowledgeable in their fields. However, it does not warrant the expertise of any author, nor is it responsible for any statements made by any author. This publication is peer reviewed; however, Special Column sections are written by editorial invitation only and are not peer reviewed.

The Kansas Nurse encourages readers to submit articles and information for publication. Requirements, deadlines and ad rates are available by emailing marketing@midwestnurses.org. The Kansas Nurse reserves the right to edit manuscripts. The association reserves the right to utilize published articles in a variety of formats and for the purpose of the organization.

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It is an honor to be a part of KSNA. Being involved with the most amazing nursing group in Kansas has continued to allow me to grow and be a part of an organization that provides so many platforms for Kansas nurses to become involved and share their voices.

The organization has completed our Membership Assembly in October 2017, our Legislative Conference in February 2018, and online surveys and membership growth activities.

Our new board members began in January 2018 with our new president, Jan Kemmerer, RN. Goals for our Kansas Board are focused on new membership, retention, on-site visits with regional groups and their meetings, and development with our schools of nursing to provide platforms for new topics and presentations. Graduating students are the future for the growth of our organization, partnering with our long-term members as mentors.

Partnering with the Multistate Division has allowed KSNA to grow in directions that include online platforms through social media and our new website. As your new director, it is my goal to make sure information on projects, opportunities, upcoming events - not only from our state but our Regional ANA and our partnering states - reaches each member. The information provided from our committees and all their hard work through the year is a focus moving forward. Sharing information, while recruiting new members, allows for the growth of KSNA. You will continue to see updates in our monthly newsletters from several of our committees, such as our Legislative Committee, Membership Committee, Bylaws, and Editorial Committee.

ANA national support at the state level continues through education and programs, such as 2017 Health Nurse Healthy Nation, 2018 programs focusing on Advocacy, and Removing Violence and Bullying in the Workplace. This is while continuing to provide current and new members with continuing education credits and multiple membership programs.

I am very excited moving into 2018 and look forward to the opportunities KSNA can provide every nurse in Kansas.

Jami Colson
State Director
Kansas State Nurses Association
As I prepare for my first board meeting as president of Kansas State Nurses Association, I am honored to be serving the nurses of Kansas and the nursing profession.

We face many challenges in our ever changing work environment from employment arrangements, staffing issues, independent practice landscape and providing nursing excellence in rural and urban settings alike.

Nurses are THE most trusted profession and although we wear this with pride, it also places a burden of responsibility to ensure that we deliver on this mantra to our patients we serve. In that vein, our involvement in the political arena is as important to our patients as the actual care we provide to them directly. Ultimately we have to protect and promote the true profession of nursing in all legislation encompassing healthcare.

KSNA has joined the Midwest Multistate Division (MW MSD) which enables us to be on the leading edge of all the trends in our industry as well as giving us the representation in numbers so critical in influencing legislation. Past President Angella Herrman was very involved with the MWMSD and she made KSNA’s presence well respected. I hope to follow in Angella’s footsteps in leading us to be ever more involved in the activities of the association.

We welcome our new State Director Jamie Colson who has been so beneficial in keeping KSNA on task and aware of upcoming issues. We are so fortunate to have her in our court.

Finally, as we move forward, I look to you our members to stay involved and engaged in our activities and committee work as you represent the highest ideals in nursing. Together we can create the best environment for nurses in the nation which results in the best nursing care for our patients.

Thank you for being the wonderful nurses you are. Please communicate freely with me as KSNA is the voice for all Kansas nurses.

Jan Kemmerer, RN
President
Kansas State Nurses Association
The MW MSD became a corporate entity in late 2016 and is governed by the Midwest Multistate Division Board of Directors. Each member State Nurses Association (SNA) has two member Board Directors, and from these a President, Vice-President, and Secretary/Treasurer have been elected. Each state contributes to the financial support of MSD operations based upon a per member rate, calculated on a percentage of MSD members from each state. MSD operations include support for administrative and management staff, technology, financial services, CE services, call center/reception services, membership services, communication and social media support, and other shared needs as identified in the future. SNAs continue to have independent, incorporated and fiduciary Boards of Directors at the state level to manage strategic and financial decisions, events, local advocacy and legislative actions. Bylaws, elections, reference proposals, membership and budgetary planning remain the responsibility of the SNAs.

The MSD employs a Division CEO to whom the following positions report:

- State Directors (FTEs determined by each state) for:
  - Kansas
  - Missouri
  - Nebraska
- Communication and Graphic Design Manager
- Administrative Coordinator
- Finance Director
- Professional Development Director
  - Nurse Planner
  - Nurse Peer Review Leader
  - Lead Nurse Planner

Lobbyists continue to be hired and paid by individual states at their discretion. Additional member SNAs will be welcomed and will offset expenses for each SNA that is a part of the MW MSD.

The MW MSD Board of Directors believes that the economy of scale created by the joint operations enhances member value and reduces expenses, while reducing the burden on volunteer leaders. Utilizing shared resources has the potential to significantly increase membership and strengthen the imprint of SNAs on nursing practice and public policy within the states.

The Kansas State Nurses Association participated fully in the development of the MW MSD as a corporation, and is dedicated to make it a successful and self-sustaining model for association operations. Previous KSNA President, Angella Hermann, and current KSNA President, Jan Kemmerer, are currently serving as the Kansas representatives on the MW MSD board.
THE 2018 KSNA LEGISLATIVE CONFERENCE WAS A HUGE SUCCESS!

Thank you to all of the presenters, nurses, and attendees who helped make this year’s conference one of the best ever.

For information on future KSNA Legislative Conferences, see page 11.
The Human Papillomavirus (HPV) is a commonly sexually transmitted infection. The Center for Disease Control and Prevention (CDC) estimates 79 million Americans are living with HPV, with 14 million new cases each year (2016a). Often, this disease is asymptomatic. The CDC states that an infected individual can spread this virus via vaginal, anal, or oral sex. If individuals are symptomatic, they will typically show signs of genital warts, or in more extreme cases, present with cancer of the cervix, oropharyngeal, penis, anus, or vagina (CDC, 2016a). Protection against HPV includes condom use, being monogamous, and the HPV vaccine, which was recommended for use by the Food and Drug Administration in 2006 (CDC, 2016b). There are more than a hundred HPV strains and the vaccine protects against nine (CDC, 2016b). The CDC (2016a) recommends that males and females aged 9 to 12 years receive the vaccine, with the ideal age being 11 to 12 years.

Although this vaccine has shown efficacy in reducing rates of HPV and HPV-related cancers, it is not without controversy. Adverse effects include fever, headache, fatigue, and nausea. More alarming is that recent research suggests this vaccine may lead to premature ovarian failure (CDCb, 2016; Colafranceso, Perricone, Tomljenovic & Shoenfeld, 2013). Premature ovarian failure (POF) is loss of ovarian function before 40 years of age, resulting in infertility. POF has been linked to a chromosomal abnormality, an autoimmune response from exposure to a virus or toxin, and/or multiple ovarian surgeries (Mayo Clinic, 2017). A literature review was conducted to examine the relationship between POF and the HPV vaccine.
Literature Review

The literature search revealed a scarcity of evidence. Only case studies were found when searching specific criteria of POF and the HPV vaccine. The following review presents six cases (five adolescents and one adult) who experienced POF after recent HPV vaccination.

Case Study 1

A 16-year-old female received three quadrivalent HPV vaccinations in 2008. According to Little and Ward (2012), she began menstruation in 2009, but by 2010, her menses became irregular before ceasing in 2011. Her follicle stimulating hormone (FSH) levels were elevated, but her luteinizing hormone (LH), estradiol, progesterone, and anti-Mullerian hormones (AMH) were in menopausal ranges. No genetic or metabolic disorders were present to explain her symptoms. Based on these results, she was diagnosed with POF.

Case Study 2

An 18-year-old female in New South Wales, Australia, reported signs of POF following administration of the quadrivalent HPV vaccination (Little & Ward, 2014). The client had an extensive medical history, including menarche at age 11 years, mild cerebral palsy, Asperger’s syndrome, anxiety, mild asthma, epileptic events, ruptured appendix, no past drug use or smoking history, no previous sexual activity, and no family history of POF. She was prescribed oral contraceptive pills at 12 years of age, and 9 months later received the first of three HPV vaccinations. At age 14 years, she discontinued the oral contraceptive pills and experienced a 3-month period of amenorrhea. Oral contraceptive pills were prescribed again, but when discontinued at 18 years of age, amenorrhea occurred. After 6 months of amenorrhea, FSH levels remained in the menopausal range. An AMH level showed decreased ovarian reserves (Little & Ward, 2014). Six months following these tests, the client was diagnosed with POF. No genetic or metabolic abnormalities were found that would explain the POF.

Case Study 3

Little and Ward (2014) discussed a second 16-year-old female from New South Wales, Australia, who was diagnosed with POF following administration of the quadrivalent HPV vaccine series. The client had no history of drug abuse, alcohol abuse, sexual activity, trauma, surgery, or a family history of POF. At 10 years of age, menarche occurred and the client did not have menstrual cycle timing issues until after her third HPV vaccination at the age of 15 years. The client experienced a 2-week delay in menstruation, and over the next year experienced only two more menstrual cycles. Other changes included hot flashes and a 10-kg weight gain. At 17 years of age, the client’s AMH levels were not detectable (Little & Ward, 2014).

Case Study 4

A 14-year-old female received three quadrivalent HPV vaccinations (Colafrancesco, Perricone, Tomljenovic, & Shoenfeld, 2013). This client experienced menarche six months prior to her first HPV vaccine injection. Other than irregular periods prior to her first dose, she had no sexual development abnormalities. Immediately following her first vaccination, she began to experience burning and a heavy sensation in the arm where she had received the injection. She also reported nausea, abdominal pain and cramping, and headaches. Following her second and third injections, she complained of the same symptoms along with insomnia, joint pain, depression, and anxiety. Her last period occurred shortly after her last injection of the HPV vaccine. Blood tests revealed an elevated FSH level, and low LH and estradiol levels. According to Colfrancesco et al. (2013), a karyotype ruled out Fragile X syndrome and mutated follicle-stimulating receptor gene, and a pelvic ultrasound revealed no ovarian abnormalities. This client was diagnosed with POF.

Case Study 5

This case study (Colfrancesco et al., 2013) involved the younger 13-year-old sister of the 14-year-old female presented in case study 4 above. Following three quadrivalent HPV vaccinations, this client experienced similar symptoms to her sister’s, along with lightheadedness, panic attacks, and difficulties concentrating. Menarche occurred at 15 years of age, and then she had a single menstrual cycle before her periods ceased. Laboratory tests revealed an elevated FSH level, and low LH and estradiol levels. Genetic testing was negative. The client did, however, test positive for antiovarian antibodies, leading to a POF diagnosis. Evidence suggested the HPV vaccine triggered the autoimmune response (Colfrancesco et al., 2013).
Case Study 6

A female had regular monthly periods (following menarche at the age of 13 years) until she received the quadrivalent HPV vaccine at 21 years of age (Colfrancesco et al., 2013). Her menses became irregular several months following her third HPV vaccination. Her menses frequency slowed until they ceased at 23 years of age. Laboratory tests revealed an elevated FSH level and low estradiol level. A karyotype evaluation ruled out Fragile X syndrome, and transvaginal and pelvic ultrasounds were negative. Thyroid hormones were within normal limits, but this client had positive antithyroid peroxidase antibodies (Colfrancesco et al., 2013). These findings led to a diagnosis of POF.

Discussion and Recommendations

According to Polit and Beck’s (2017) classifications, these case studies are not a high level of evidence. Nonetheless, the case studies suggest a relationship between the HPV vaccine and POF. There may be a group of females for whom the HPV vaccine is contraindicated, but due to the voluntary reporting of side effects, it is difficult to accurately assess these reactions (Colafrancesco et al., 2014). A cohort study should be established for long-term follow up of ovarian function in females following HPV vaccination (Colafrancesco et al, 2014). Ovarian function should be examined prior to vaccination, such as evaluating FSH, LH, AMH, and estradiol levels.

It is important to note that AMH levels in females do not peak until the age of 15.8 years, and begin to decline after 25 years of age (Little & Ward, 2014). However, many adolescent females receive the vaccine prior to their peak AMH level being established. This may be because the CDC recommends HPV vaccination occur as early as 9 years of age, and ideally at 11 to 12 years of age (CDC, 2016b). Cohort studies that obtain intermittent AMH levels should be conducted to monitor female menses with vaccinated and unvaccinated individuals (Little & Ward, 2014). There is also evidence that the HPV vaccine may be linked to an autoimmune response in individuals susceptible to POF (Colafrancesco et al., 2013). This relationship should be further explored.

Due to the use of oral contraceptives, there are POF cases that have not been identified (Little & Ward, 2014). Oral contraceptive use, alongside the HPV vaccine administration, needs to be examined further. Females taking oral contraceptives who received the HPV vaccine should have FSH and LH levels monitored yearly.

A diagnosis of POF is devastating because it translates to infertility at an age younger than when many women consider conceiving a child. Evidence presented suggests the need to clearly identify risks and benefits of HPV vaccination. Because the vaccine has been widely administered for little more than 10 years (CDC, 2016b), it is difficult to evaluate its long-term effects. This review supports that more research is needed to better understand the relationship between the HPV vaccine and POF.

References


SAVE THE DATES!

The following dates have been confirmed for the

2019 & 2020 KSNA LEGISLATIVE CONFERENCES

2019
Wednesday, March 6, 2019

2020
Wednesday, March 4, 2020

EVENTS WILL BE HELD AT CAPITOL PLAZA HOTEL TOPEKA
Welcome to the
KANSAS STATE NURSES ASSOCIATION

Those who joined from September 2017 – February 2018

Katherine Adams
Karen Adamson
Amanda Addis
Ladonna Andritsch
Jacquelynn Asherman
Traci Atzenweiler
Cherie Bahm
Rosetta Bard
Katherine Barker
Kara Bartlett
Nicole Bath
Amanda Bentley
Kim Bieler
Brenda Blake
Lucinda Bonjour-Molden
Natalie Boyd
Ginger Breedlove
Robert Brown
Angela Bueno
Margaret Burghart
Kourtney Burnett
Angela Cammarn
Cornelia Campbell
David Campbell
Amy Carr
Janet Cellitti
Rachel Cessna
Jennifer Clark
Jessica Clasen
Nicki Cleveland
Marie Coffin
Kelly Cole
Kelsie Coltrane
Timothy Conaway
Drew Conger
Samantha Conley
Leslie Cox
Dinel Cropper
Hannah Dalke
Jeremy Donnelly
Ginger Douglas
Holly Edmonds
Miranda Erwin
Kylie Eustice
Christina Everts
Kara Fairbanks
Jennifer Falk
Channya Farley
Stephanie Farley
Suzanne Fletcher
Hope Flynn
Kim Foos
Linda Foster
Brianna Fredrickson
Rachel Garcia
Jessica Gay
Jenanne Gerstenkorn
Misty Gomez
Jacqueline Groeneveld
Lacey Grogan
Amber Grossard
Desideria Guela
Michele Guthrie
Jessica Hackmeister
Megan Hailey
Laura Hamilton
Melissa Haverkamp
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Barbara Holm
Karen Hooker
Erin Hosler
Polly Howell
Sara Huntwork
Rebecca Hurla
Kristine Irwin
Rebekah Jensen
Tracy Johnson
Charlsie Johnson-Wilson
Leslie Jones
Alyson Kastler
Ashley Kautz
Elizabeth Kelly
Chandalynn Kenestrick
Jeanee Kennedy
Danielle Keomany
Michelle Knight
Melissa Kringen
Sharon Krum
Dena Lankard
Andrea Leiker
Billie Leonard
Deborah Lesher
Jennifer Lix
Angela Lowery
Rebecca Lukehart
Korie Mahner
Leslie Malle
Molly Mansur
Kinnie Mapes
Bridget Marshall
Diane Marteney
Jami McCabe
Marianne McCorkill
Jerri McKnight
Julie Merchant
Sarah Meuser
Sonya Miller
Meghan Moberly
Paul Murphy
Chynessa Myers
Samantha Myers
Judy Nelson
Laura Nelson
Megan Nelson
Nora Nokes
Tamara Norman
Roxann Norrick
Sarah Oehmke-Lejuerne
Catherine Olguin
Michelle Osborne
Brandy Patterson
Heather Penka
Michelle Pennington
Jessica Pfeifer
Jaime Pooe
Pam Reeder
Charlotte Renollet
Hello and Welcome to
Kansas State Nurses Association!

We are so excited to have you join our professional nursing organization and want to help you get the most out of your membership! Whether your interest lies with advocacy and the legislative process or continuing education and best practices, Kansas State Nurses Association has something for every nurse! We have several committees for nurses to join, including the Legislative Committee, the Editorial Board, which publishes The Kansas Nurse, and the Bylaws Committee to name a few. Becoming involved provides opportunities to network with those closer to home. Please email me if you would like more information on any of these groups or if you want to get more involved.

Please explore our website for the latest updates on advocacy and to learn more about membership benefits (http://www.ksnurses.com). Included in our welcome packet, you will find a letter from our Kansas State Nurses Association President, Jan Kemmerer, instructions on how to log onto our website, and general information about KSNA and how to get involved.

Let me know if you need anything and again, thank you for joining.

Together, we are the Voice and Vision of Nursing in Kansas!

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Jami Colson
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Violence against nurses

Chelsey Mann

“The most serious incidents of aggression and violence are reported in healthcare facilities” (Kaur & Kaur, 2015, p. 124).

When thinking about the field of nursing, violence is not the first thing that comes to mind because this topic doesn't receive enough attention. Usually we think about nurses playing the role of caregiver to all of their patients. However, being a nurse involves many tasks, with a couple examples being health teaching and nursing diagnoses. Juggling a multitude of tasks means the profession of nursing is incredibly demanding and stressful, and while nurses have to manage all of these things, they also have to maintain patient-centered practice. Patients and their relatives or visitors may become aggressive and violent toward healthcare professionals on a daily basis, regardless of the effort nurses make to meet all possible patient needs. In an article, Kaur and Kaur (2015) stated that, “professions within the healthcare industry are becoming increasingly violent places in which to work with healthcare professionals being common targets for violent and aggressive behavior” (p. 124).

Violence is most commonly classified as physical, sexual, or verbal. Some examples of physical violence or abuse are being spit on, bitten, pushed, scratched, or hit. Sexual violence or assault refers to any unwanted physical or sexual behavior inflicted on a
person. Verbal violence or abuse can be experienced through “words, tone of voice, threats, accusations, or disrespecting another person, and refers to any form of mistreatment, spoken or unspoken, that leaves a victim feeling personally or professionally attacked, devalued, or humiliated” (Kvas & Seljak, 2015, p. 178). When nurses experience any kind of violence directed at them, it becomes more difficult to remain committed to patient-centered care, as well as to maintain ethical boundaries. The purpose of this paper is to identify ways to give more attention to the issue of violence toward nurses and to explore multiple interventions that could be used to minimize the occurrence of violence, or prevent violence toward nurses completely.

To understand the issue of violence against nurses and how prevalent it is, it is important to look at history and statistics. Violence is experienced physically, sexually, and verbally, but, it also comes from a variety of sources and can be seen in various clinical settings. According to Shea, Sheehan, Donohue, Cooper, and Cieri (2017), “the dominant sources of occupational violence and aggression (OVA), were patients (79%) or relatives of patients (48%)” (p. 236). Regardless of who causes the violence, every healthcare professional, including nurses, has experienced some form of violence. In fact, nurses are the ones that experience workplace violence the most (Kaur & Kaur, 2015). Kvas and Seljak (2015) also wrote about how sources of violence can be divided into two categories; internal and external. Internal sources of violence include other nurses and physicians, and external sources of violence would be patients and the patients’ relatives. Leaders in a healthcare facility, such as physicians, play an important role in preventing and managing violence. It is said that, as leaders, “they are supposed to serve as role models and should not represent a source of violence” (Kvas & Seljak, 2015, p. 178). However, they often become the source of the violence.

Multiple studies have been done to evaluate the prevalence of violence toward nurses. A study about the violence experienced in a ward of the Guru Nanak Dev Hospital showed that 100% of staff nurses experienced assault. It also revealed that 97% experienced assault one to five times during their current ward experience. In this ward, verbal assault was found to be more prevalent as 99% of the staff reported experiencing verbal assault compared to one person experiencing physical assault. (Kaur & Kaur, 2015).

An article by Jackson (2002) noted a declining nursing workforce in which there is violence and hostility, which is part of the day-to-day life of most nurses (Kaur & Kaur, 2015). According to a study conducted by Michael Privitera (2006), 43% of people reported being threatened and 25% being assaulted (Kaur & Kaur, 2015). Another study by Jessica Gacki (2009) reported that, “25% of people reported experiencing physical violence more than 20 times in the past 20 years and almost 20% reported experiencing verbal abuse more than 200 times during the same period” (Kaur & Kaur, 2015, p. 126).

According to Koller (2016), as high as the numbers are, the actual number of incidents is higher due to underreporting because of the perception held by nurses that assaults are ‘part of the job’. Only a small percentage of workplace violence victims report violent incidents because of the belief that violence is an occupational hazard that goes along with healthcare (Kvas & Seljak, 2015).

According to Demshar (2015), “current law provides enhanced penalties against aggressors who attack nurses and other healthcare workers and emergency responders in emergency rooms, but not in other locations” (p. 10). The article continues by stating that, “hospitals and other facilities where nurses work need to implement policies and procedures that protect nurses and punish offenders” (Demshar, 2015, p. 10). Violence against nurses is more common than it should be, and there are multiple interventions that could be implemented to help minimize or prevent violence towards nurses.

Research has suggested many ways to intervene when it comes to patients behaving violently. Some examples of interventions include education about interventions, safety tips about interventions, maintaining a safe workplace environment, identifying issues and creating a plan of action, educating the public, urging nurses to report perpetrators, and the use of laws.

To evaluate the effectiveness of education about interventions, a study developed by Adams (2017)
examined three objectives. These objectives are to evaluate the effectiveness of education and the staff’s ability to identify patients that are a high risk for violence, determine if education affects the frequency of workplace violence, and determine if education influences violent incidences by repeat perpetrators (Adams, 2017). Also, a before and after study was developed to evaluate the educational interventions and assess knowledge, confidence, and capability of staff when it comes to managing violence and aggression (Adams, 2017). The before and after study consisted of a questionnaire to assess the staff’s knowledge about preventing or managing workplace violence or aggression using a one-to-five Likert Scale. This questionnaire included information regarding coaching, which enhanced the staff’s skills for managing violence or aggression. The outcome of the study proves that, “knowledge related to violence/aggression improved significantly as did the use of verbal de-escalation, and consequently both the frequency of incidents and the number of recurring incidents decreased” (Adams, 2017, p. 14).

A study by Koller was conducted supporting the idea of staff being proactive with their training and interventions when it comes to violent patients. It also emphasizes the importance of staff education, and focuses on three specific aspects of education. Those include, “creating a safe environment, recognizing and evaluating the behaviors of potentially violent patients, and identifying nurses’ behaviors that may trigger patient violence” (Koller, 2016, p. 356). This study used ten different strategies to evaluate the effectiveness of the three aspects of education mentioned above. A couple of examples of the strategies they used are identifying patient characteristics that may hint at possible violence and to staying near the exit of a patient’s room in case violence may occur. After completing this study, it is difficult to say that one single strategy is the key to ending all violence, but by following these strategies, staff will feel safe and the occurrence of violence will decrease.

Kvas and Seljak (2015) developed a study to determine sources and prevalence of workplace violence. It is
believed that in order to prevent and eliminate violence, the type, frequency, and degree of the violence must be determined. To determine the type, frequency, and degree of violence, a questionnaire was used. This questionnaire showed that verbal violence was the most common form of violence against nurses since 60.1% of nurses experienced it. Physical violence occurred less frequently, but was still experienced by 26% of nurses. The most common source of verbal violence toward nurses were from co-workers (39.6%), patients (39.3%), and physicians (36.1%). Looking at physical violence, patients were found to be the most frequent source (20.8%).

According to Demshar (2015), a safe environment will ensure physical and psychological well-being. If healthcare professionals don’t feel safe, the workplace environment is vulnerable, and everyone’s safety is compromised. Demshar (2015) also supports educating staff members about vulnerabilities in the workplace and how to reduce them to prevent violence from occurring. She also stresses the importance of nurses reporting perpetrators to the authorities so something can be done about the violence that occurred. In addition, hospitals need to implement policies and procedures that protect nurses and punish offenders, and law enforcement and state attorneys must be encouraged to arrest, charge, and prosecute perpetrators (Demshar, 2015).

In addition to all of the interventions listed above, there is one more that hasn’t been mentioned. That is making a rule prohibiting inpatient visitors. To have a rule such as this would ensure that violence against nurses would decrease or completely stop; however, for multiple reasons, this intervention is not beneficial for the patients. To correlate this, a trial was done for twenty-four months that involved 381 patients. After completing this study, the results indicated that unrestricted visitation did not increase septic complications, but it was beneficial for patients in terms of reducing cardiovascular complications and anxiety levels when visitation is allowed compared to when it was restricted (Casey, 2017). As supported by research, restricting visitation for patients would not be beneficial; therefore, this intervention should be avoided in nursing practice.

In conclusion, multiple studies support that violence against nurses is more common than people realize and something needs to be done about it. Interventions such as education, safety tips, maintaining a safe workplace environment, creating a plan of action, educating the public, urging nurses to report perpetrators, and using laws demonstrate that interventions reduce the occurrence of violence towards nurses. The nurse’s role in all of this is to be open and willing to learn and implement these interventions in their everyday nursing practice. The key to all of these interventions is education. Education about how to determine if violence will occur, how to prevent violence from happening, and how to maintain a safe workplace environment will reduce the occurrence of violence toward nurses. Not only that, but nurses will be able to manage a violent event in a safe and professional manner if it does occur. Education about violence will ensure a safer environment for everyone, especially nurses.

References


Seen through the leaded glass windows was the rushing traffic on Topeka Boulevard in Topeka, Kansas. The original home built for William T. Crosby, kept with his prominence and affluence, Crosby built one of the finest houses on the most fashionable streets in the capital city. The house is located at 1109 Topeka Avenue and is the neighbor to the also-famous Charles Curtis home. Both amazing homes are now on the National Register of Historic Places.

The home has had several owners over the years, including the Grand Chapter of the Eastern Star of Kansas, and most recently the Kansas State Nurses Association (KSNA). The building has housed many KSNA Board meetings, Board Presidents, staff and State directors over the last seven years. The patrons who entered through the grand doorways could feel the history, especially when looking up to the Grand original staircase - all of which has been preserved over the years.

December 6th, 2017, the KSNA sign was removed from the entryway for the new owners to begin many new memories within the three-story brick building.

Due to the sale of the office, all the historical items needed to be moved. To preserve the history of the organization, these items were packed in storage boxes and placed at a local climate-controlled storage unit in Topeka. The items/documents are available to be organized further by our Archives committee or the state director when documents are requested. Moving forward, the Board may request that all documents be saved and preserved through scanning. Due to the short time frame for the new owners to take ownership, we were unable to scan all documents prior to the move. Please let the state director know requests for items, with the goal that each box will be reviewed and removed in a timely manner to minimize the length of time needed for a storage facility. Details for this, I am sure, will be a topic for the Archives committee and the future Board meetings in 2018.

It is such an honor to work with each one of you, and I look forward to all the progress KSNA will achieve for our Nurses in Kansas in 2018!

Moving forward the contact information for KSNA is:
Jami Colson, State Director
director@ksnurses.com
785-233-8638 x300

KSNA mailing address:
c/o Midwest Multistate Division
3340 American Avenue, Suite F
Jefferson City, Mo. 65109
ANA represents the interests of the nation’s 3.6 million registered nurses through its constituent and state nurses associations and organizational affiliates.

1 in 45 potential voters in the U.S. is a nurse.

Projected Employment Growth
According to the U.S. Bureau of Labor Statistics...

16.9% Projected job growth over the next decade

1.2 Million Vacancies for RNs and APRNs between 2014 and 2024
An Increase of nearly 500,000 new jobs

The Past 16 years
the public has voted nurses as the most honest and ethical profession in America*

*According to Gallup’s annual survey

www.ksnurses.com

www.nursingworld.org
The Year of Advocacy

ANA has declared 2018 as the ‘Year of Advocacy.’ Throughout the year, ANA members advocating for patients and the profession will be featured. Be sure to check RNAction.org for updates throughout the year and share your advocacy story on social media using hashtag #BedsideAndBeyond. Quarterly themes will build from local to national illustrations of advocacy.

Q1 | NURSES ADVOCATING LOCALLY

Q2 | NURSES INFLUENCING ELECTED OFFICIALS AND OTHER KEY DECISION MAKERS

Q3 | NURSES GET OUT THE VOTE!

Q4 | GLOBAL IMPACT AND MAKING EVERY YEAR A YEAR OF ADVOCACY

The Past 16 years the public has voted nurses as the most honest and ethical profession in America. According to Gallup’s annual survey 1 in 45 potential voters in the U.S. is a nurse.

Projected Employment Growth

1.2 Million Vacancies for RNs and APRNs between 2014 and 2024

Projected job growth over the next decade 16.9%

1 in 45 potential voters in the U.S. is a nurse.

ANA represents the interests of the nation’s 3.6 million registered nurses through its constituent and state nurses associations and organizational affiliates.
UPCOMING EVENTS

JUNE 2018

JUNE 21

ANA LOBBY DAY
Washington, DC

JUNE 22-23

2018 ANA MEMBERSHIP ASSEMBLY
Washington Hilton Hotel
Washington, DC

More events are being added all the time!
For the most up-to-date list, be sure to visit our event calendar at:

www.ksnurses.com/events
Implementation of TEAMSTEPPS® in a Baccalaureate Nursing Program

Background

In 1999 the Institute of Medicine (IOM) released the groundbreaking report on patient safety, To Err is Human (Kohn, Corrigan, & Donaldson, 1999). This report motivated the Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD) to enhance efforts to improve patient safety. In 2006, a standardized program focused on team training for health care professionals was released by AHRQ in cooperation with the DoD. The training, titled Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), addresses the challenges of communicating in complicated health care environments (Baker, Beaubien, & Holtzman, 2003; Baker, Gustafson, Beaubien, Salas & Barach, 2005). TeamSTEPPS® provides health care team members with evidence-based communication tools and techniques to facilitate communication amongst team members. The four TeamSTEPPS®
competency areas described as critical for patient safety are: leadership, situational monitoring, mutual support and communication.

Clinical teams function at a high rate of safety and efficiency when professional nurses are trained in techniques that enhance their ability to communicate. In addition, patient-focused quality outcomes are improved when health care teams communicate effectively (Mesmer-Magnus & DeChurch, 2009; Ellingson, 2002). With this in mind, the purpose of this educational innovation is to integrate TeamSTEPPS® concepts into the curriculum of an undergraduate baccalaureate nursing program to prepare students for safe and efficient practice as RNs. The implementation process began by providing the TeamSTEPPS® Master Trainer course to over half of the school of nursing faculty followed by a comprehensive plan for curricular integration. With administrative support, the baccalaureate faculty mapped TeamSTEPPS® competencies to the appropriate level and course within the curriculum. These concepts were then and continue to be taught in the didactic, clinical, community, and simulation settings. Upon completion of TeamSTEPPS® content in the curriculum, baccalaureate nursing students graduate with a certification in TeamSTEPPS®.

Framework

The framework faculty chose for the project was Lean Six Sigma (LSS). Adapted by businesses from manufacturing to health care, the aim of LSS is to increase performance and decrease redundancies within an organization. LSS stresses efficient use of time, resources, and encourages employees to search for data-driven solutions. A suggestion found in the literature revealed there may be a benefit to combining the tools of LSS with some of the tools and goals of the TeamSTEPPS® curriculum. Lean Six Sigma is thought to support and complement the collaboration and communication techniques taught in TeamSTEPPS® (Rivera, 2015).

Literature Review

TeamSTEPPS® training has been implemented in a variety of clinical settings, particularly in high risk areas, to improve communication and patient safety. Research has documented significant positive effects from this training in both team communication skills and patient outcomes (Brodsky et al., 2013; Harvey, Wright, Taylor, Bath, & Collier, 2013; Lisbon et al., 2014; Mayer et al., 2011; O’Byrne, Worthy, Ravelo, Webb, & Cole, 2014; Sawyer, Laubach, Hudak, Yamamura, & Pocrnich, 2013; Tibbs & Moss, 2014; Vertino, 2014). From trauma center to emergency departments, team performance has been impacted after TeamSTEPPS® training, noted by significantly improved knowledge and attitudes related to teamwork among staff (Harvey et al., 2013; Lisbon et al., 2014; Mayer et al., 2011). Several studies in the surgical and OB settings note improvements after TeamSTEPPS® training. Effective teamwork evidenced by significant improvement in team members present for timeout (Tibbs and Moss, 2014) and increased challenges made to incorrect medication orders and inadequate chest compressions were documented (Sawyer et al., 2013).

Five studies identified TeamSTEPPS® implementation and research conducted in an academic setting. All documented significant improvements in student perceptions of teamwork and in communication skills with a variety of approaches to curricular integration of the TeamSTEPPS® principles (Baker & Durham, 2013; Brock et al., 2013; Liaw, Zhou, Lau, Siau, & Chan, 2014; Maguire, Bremner, Bennett, & VanBrackle, 2015; Meier et al., 2012). Baker & Durham (2013) implemented an interprofessional didactic course with embedded TeamSTEPPS® principles and found collaborative competencies were improved among the medical, pharmacy and nursing students who participated. Brock et al. (2013) in a study with medical, nursing, pharmacy and physician’s assistant students measured a significant effect on both knowledge and attitudes toward the teamwork principles of situation monitoring, mutual support and communicating in interprofessional teams. Liaw et al. (2014) also found significant impact in communication effectiveness in a simulation based interprofessional educational experience with medical and nursing students using TeamSTEPPS® principles. Of particular interest to our research team, Maguire et al. (2015) document a significant impact on teamwork attitudes over time with the integration of TeamSTEPPS® principles in simulation experiences in a sample of 108 undergraduate nursing students over four semesters in a baccalaureate nursing program.

Methods

Students in their first semester of nursing school were provided an informed consent form (after Internal Review Board approval), the TeamSTEPPS® Benchmark Tool and
the Teamwork Attitudes Questionnaire (T-TAQ). These questionnaires are designed to evaluate the baseline knowledge and attitudes of nursing students prior to any TeamSTEPPS® training. In their fourth semester, students were re-evaluated using the same tools.

Next, TeamSTEPPS® communication concepts were threaded through the undergraduate nursing curriculum in didactic, simulation, community and clinical experiences with the goal of providing a stronger foundation for the students’ knowledge, skills, and attitudes related to teamwork and communication in various clinical situations. The concepts were introduced in the following stages:

- Semester 1: SBAR, Check-Back, Hand-off, Two-Challenge Rule, CUS
- Semester 2: Call-Out, Brief, Debrief, Huddle, Task Assistance, Feedback
- Semester 3: I Pass The Baton, STEP, Advocacy & Assertion
- Semester 4: Effective Team Leaders, Cross Monitoring, I AM SAFE, Advocacy & Assertion, DESC Script

To prepare faculty to teach and incorporate the tools from TeamSTEPPS®, faculty at each level were trained with both the TeamSTEPPS® Master Trainer two-day course and Lean Six Sigma. Combining these two trainings for faculty was designed to improve their communication skills and knowledge of efficiency approaches currently utilized in the health care and business settings. In turn, this prepared them to teach these approaches to students. Adjunct faculty were provided and encouraged to access an on-line TeamSTEPPS® module. All faculty were provided the TeamSTEPPS® pocket guide to use in the clinical, simulation, community and didactic settings.

To evaluate student learning, two tools were used. The Learning Benchmark tool consists of 23 multiple-choice test items. This benchmark exam evaluates both content knowledge and applied knowledge using vignettes that focus on health care teamwork, communication, and the effect of these on quality and safety in patient care. The T-TAQ includes 30 items, assessing and measuring students’ attitudes towards the core components of teamwork in healthcare. Using a 5-point Likert-type scale (1 = strongly agree to 5 = strongly disagree) five concept areas are assessed: Team Structure, Leadership, Mutual Support, Situation Monitoring, and Communication. The T-TAQ is shown to have strong evidence of internal consistency and reliability for the teamwork constructs with a Cronbach’s alpha coefficient of 0.70, 0.81, 0.83, 0.70, and 0.74 respectively. (Maguire, Bremner, Bennett, & VanBrackle, 2015; Baker, Krokos, & Amodeo, 2008; Baker, Amodeo, Krokos, Slonim, & Herrera, 2010).

**Summary**

By the Fall of 2016, four semesters of data had been collected. The pre-testing aggregate student scores ranged between 78% and 82% on the Learning Benchmark tool. Exit scores for four class cohorts ranged between 89% and 97% on the Benchmark tool. Students most frequently missed questions related to the TeamSTEPPS® concepts of delegation, assertiveness, and conflict resolution. Test questions most frequently missed were similar in both groups. Results from these and future evaluations will be used to guide TeamSTEPPS® concept emphasis within the curriculum.

Currently, sufficient data to compare the same year cohort pre and post scores does not exist. Eventually, comparisons will be made of the same student cohort over their four semesters. This will determine if individual students’ scores improve over the course of nursing school and demonstrate that students’ knowledge is increasing due to their training on TeamSTEPPS® concepts. Moving forward, data analysis of the T-TAQ pre and post scores will be completed and analyzed, as well.

With great emphasis in the current health care environment on patient safety, efforts to develop communication skills and improve efficiency in the preparation of students soon to be practicing RNs is both timely and adds significant value to students as future employees. Building these skills in both faculty and students will prepare all of these clinicians for the dynamics of the current clinical practice environment. The nursing program will continue to train all full, part time, and adjunct faculty in TeamSTEPPS® communication and leadership principles. Ongoing training also includes other disciplines on campus, such as physical therapy, occupational therapy and respiratory therapy; this interprofessional approach to training will continue with emphasis on increasing opportunities for interprofessional learning. Long-range planning is to extend TeamSTEPPS® training to local health care agencies and their employees. Many large clinical agencies in Northeast Kansas already have been exposed to or have
implemented TeamSTEPPS® training. We believe the inclusion of this leadership and communication training enhances our students both in the marketplace and more importantly as advocates for patient safety and makes our student graduates more competitive in the job market as future employees.

References


The Board of Trustees of the Kansas Nurses Foundation is grateful to everyone who provided support for nursing scholarships at the KSNA Membership Assembly on October 21 in Wichita. Unfortunately, due to limited attendance numbers, KNF had to cancel its first scholarship breakfast. However, those KSNA members who had registered for the breakfast were kind to provide their fees as outright donations to KNF for funding scholarships that will go to nursing students across the state.

In total, more than $900 dollars were raised that day in October to benefit KNF’s work; nearly $500 through the donated breakfast fees and more than $400 through the silent auction of items/baskets. Watch for your KNF group again at the upcoming KSNA Legislative Day on February 14 in Topeka. Information about applying for scholarships will be available as well as another FUNdraising effort for everyone to enjoy.

Again this year, KNF will be conducting a year-end appeal mailing to all KSNA members seeking your support for nursing scholarships through the Florence Nightingale Annual Giving Fund. Please consider KNF in your year-end giving; donations are tax deductible according to law because KNF is a 501(c)(3) nonprofit organization, approved and listed with the Kansas Secretary of State’s office. We always appreciate your support. Thank you for helping to assure the future of professional nurses in Kansas.

Michele Reese
Administrative Assistant
Kansas Nurses Foundation
2017 KNF SCHOLARSHIP RECIPIENTS

APRN SCHOLARSHIP
Katie Fee, DNP – Mission, University of Kansas

CONNIE SCHEFFER PUBLIC HEALTH SCHOLARSHIP
Amanda Huerta, BSN – Kansas City, KS, University of Kansas

ELLEN K. CARSON SCHOLARSHIP
Tammy Newberry, BSN – Lyndon, Washburn University

GEORGE DEVANE CRNA SCHOLARSHIP
Leah Coyle, CRNA – Olathe, University of Kansas

GLENN & GRETA SNELL SCHOLARSHIP
Sarah Miller, DNP – Leavenworth, University of Missouri

HESTER L. THURSTON SCHOLARSHIP
Josephine Baker, BSN – Lawrence, University of Kansas

JAMES E. SEITZ KANS
Katelynn Hoobler, APRN – Topeka, Baker University

KNF GENERAL SCHOLARSHIP
Angela Jackson, ADN - Olathe, Johnson County Community College
Paige DeLay, BSN – Holton, University of Kansas

KSNA DISTRICT 2 SCHOLARSHIP
Alaiha McDaniel, ADN – Overland Park, Johnson County Community College

KSNA DISTRICT 7, DOROTHY ASTLE SCHOLARSHIP
Robert Wilson, ADN – Overland Park, Johnson County Community College

KSNA DISTRICT 9, DOROTHY LADD SCHOLARSHIP
Mary Kate Roy, BSN – Louisburg, University of Kansas

MORGAN-SANDERS SCHOLARSHIP
Laurissa Beckman, CRNA – Louisburg, University of Kansas

ROBERTA THIRY SCHOLARSHIP
Drue Bailey, BSN – Olathe, University of Kansas
Marissa Gatti, BSN – Overland Park, University of Kansas

WESLEY SCHOOL OF NURSING ALUMNI
Miranda Ferris, BSN – Sedgwick, Fort Hays State University
KSNA 2018 LEGISLATIVE PLATFORM

As the largest group of health care professionals in any health care unit, nurses have a vital interest in enlightened legislation. The Kansas State Nurses Association provides leadership for the nursing profession and promotes quality health care for consumers through education, advocacy, and influencing of healthcare policy.

NURSING PRACTICE AND EDUCATION

As the professional association for registered nurses, KSNA supports:

1. Recognition of the KSBN as the sole regulatory authority for professional nursing practice and the provision of adequate funding for the agency.
2. Representation by KSNA, or their designees, on all interdisciplinary bodies concerned with planning, implementing and evaluating health care services.
3. Ensuring the composition of the KSBN includes members whose professional qualifications relate to the functional responsibility of the state regulatory agency for nursing practice and nursing education.
4. Promoting the role and protecting the practice of registered nurses. Nurses should practice to the full extent of their education and training.
5. Efforts aimed at addressing an adequate supply of nursing work force include expanding state funding to educate more nurses at all levels of nursing and encourage recruitment and retention in nursing by employers.
6. Funding for research to maximize nursing’s contribution to health, nursing education programs, nursing faculty salaries, and advanced education for nurses.
7. Programming efforts that encompass education, prevention, and treatment/interventions related to the opioid crisis.

WORKPLACE ADVOCACY

As the professional association for registered nurses, KSNA supports:

1. The right of nurses to official representation on employment matters affecting them as employees and as professional practitioners.
2. Maintenance of laws germane to the practice of nursing.
3. Nurse driven staffing ratios that ensure quality patient care.
4. Enactment of legislation that protects the economic and employment rights of nurses, including their right to advocate for patients.
5. Policy initiatives to provide education for health care providers in awareness of violence potential, de-escalation methods, actions to take in a violent incident.

CONSUMER ADVOCACY

As the professional association for registered nurses, KSNA supports:

1. Policy that ensures equal access to all health care services and nursing care across the life span for individuals in the state of Kansas.
2. Establishing, implementing, and maintaining safeguards for the rights of all citizens, especially children, senior citizens, the disabled, and the economically and socially disadvantaged.
3. Efforts aimed at physical and mental health promotion, early intervention, treatment, and referral.
4. The ability of individuals to select an appropriate health care provider of their choice.
5. Initiatives to eliminate substance abuse including tobacco, alcohol, legal, and illegal drugs.
6. Legislative efforts to fund education and prevention programs and treatment/intervention therapies related to the opioid crisis.

OCCUPATIONAL AND ENVIRONMENTAL HEALTH

As the professional association for registered nurses, KSNA supports:

1. Legislation and regulation that promotes workplace safety and promotes occupational and environmental health.
2. Resources to increase the capacity of nurses to prepare and respond to disasters.
3. Research and education for the prevention and treatment of occupational and environmental health issues, through evidenced-based health policy initiatives.
4. Efforts to provide a safe, non-threatening collegial work environment by instituting policy preventing bullying behaviors.

FINANCING HEALTH CARE

As the professional association for registered nurses, KSNA supports:

1. Funding to provide health care, mental health services, food, and shelter to persons in need.
2. Funding for state health plans, public health, and public health nursing services.
3. A health care system that provides quality care, quality of life, and patient safety.
4. The use of evidence-based cost containment incentives to provide an affordable health care delivery system for all citizens.
MEMBERSHIP: Carol Moore, Presiding
MEMBERS PRESENT: Brandy Jackson, Delyna Bohnenblust, Sarah Tidwell, Karen Roberts, Mary Lisa Joslyn
MEMBERS ABSENT: Terri Roberts, Amy Mason, Bridget Camien
STAFF: Jami Colson, Angella Herrman

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DISCUSSION</th>
<th>ACTION PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Introductions</td>
<td>Brief introductions made.</td>
<td></td>
</tr>
<tr>
<td>II. Approval of agenda/additional items</td>
<td>Motion made and 2nd by Dee/Sarah to approve the agenda. Carol added a discussion on violence in the workplace.</td>
<td></td>
</tr>
<tr>
<td>III. KSNA platform review.</td>
<td>Review of the 2017 Legislative Platform occurred in preparation for presentation to the Membership Assembly on Oct 21st. Revision made and distributed via email for final committee approval.</td>
<td></td>
</tr>
<tr>
<td>IV. Ideas for committee coverage, Tracking bills, Sharing alerts to issues/new bills</td>
<td>In order to have enhance committee member involvement and legislative bill monitoring, the group “adopted” legislative committees to follow for issues of significance for nursing.</td>
<td>This KSNA committee will keep each other apprised of progress of bills and submit to TKN information for the KSNA membership. Senate Health &amp; Human Services: Brandy House Health and Human Services and Insurance: Sarah House Transportation, Transportation Public Safety Budget: Dee House Judiciary: Karen Carol will monitor other committees and coordinate communications within this KSNA committee. Karen shared the link to the Kansas Health Institute <a href="http://www.khi.org/connect#newsletter">http://www.khi.org/connect#newsletter</a> Carol is not able to forward the Hawver’s Capital Report to the committee (small print at the bottom states “do not forward, under penalty of law”) reminder to always read the small print. Women for Kansas information can be located at <a href="http://womenforkansas.org/news-we-can-use/">http://womenforkansas.org/news-we-can-use/</a></td>
</tr>
<tr>
<td>V. Sharing requests for support from legislators. Response?</td>
<td>Carol shared with the group the requests KSNA has received from some legislators requesting KSNA support and donations to their campaigns. It was agreed that we should acknowledge the requests with tactful explanations that we cannot provide monetary support.</td>
<td>Carol will draft a letter and distribute to the committee for editing.</td>
</tr>
<tr>
<td>VI. Workplace violence</td>
<td>A brief discussion ensued regarding the articles Carol sent out prior to the meeting.</td>
<td>A notification to the membership will need to be approved by the KSNA board before distribution regarding the rally scheduled for Nov 1st in KC.</td>
</tr>
<tr>
<td>VI. Planning for next meeting</td>
<td>Scheduled for Dec 5th, Tuesday evening at 7:00 pm (per phone)</td>
<td></td>
</tr>
</tbody>
</table>

Adjournment at 8:00 pm Moved/seconded Karen/Brandy
RESPECTFULLY SUBMITTED: CAROL MOORE

LEGISLATIVE COMMITTEES:
SENATE: Health & Human Services | Social Services Budget | Transportation | Transportation & Public Safety Budget
HOUSE: Children and Seniors | Corrections & Juvenile Justice | Health & Human Services | Social Services Budget | Transportation | Transportation & Public Safety Budget | Judiciary
SPECIAL COMMITTEES: Bob Bethell KanCare Oversight Committee
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UPCOMING KSNA BOARD MEETINGS

**APRIL 16, 2018 @ 6PM**
Phone conference

**JUNE 9, 2018 @ 10AM-12PM**
Prairie Band Casino board room
The Kansas Nurse
Vol. 93, No. 1 :: The Kansas Nurse | 31

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PRACTICE COUNCIL
Vacant

KSNA Bylaws Committee

CO-CHAIRS
Cindy Reazin, MSN, APRN, CNS-BC & Terri Johnson, MSN, APRN

Julie Miller and Marjorie Sams-Dillon continue as committee members. After KSNA members approved changes at the 2016 Membership Assembly, approved changes were sent to the ANA Bylaws Committee and KSNA Bylaws Committee members began working on two sets of proposed changes. One of the needed Bylaws changes dealt with when and how the KSNA Board of Directors met, and the other dealt with KSNA’s relationship with the Midwest Multistate Division. Committee members dealt with the proposed changes via emails. Both sets of changes were presented at the 2017 Membership Assembly and were approved. Word has been received from the ANA Bylaws Committee that the KSNA Bylaws have now come to the top of the list for review, and the ANA Bylaws Committee will review them, with the newly approved ANA Bylaws changes in mind, and give recommendations for any changes needed. The KSNA Bylaws Committee is now in position to review the three Regional Bylaws they have received, and will begin working on the changes needed for the KSNA Bylaws to correctly reflect the Value Pricing Dues KSNA is now participating in.

KSNA STANDING COMMITTEES, COUNCILS & EVENT PLANNING

GROUP GENERAL GUIDELINES

Can be found on the KSNA website at:

www.ksnurses.com membership/ committees-councils/
LET'S GET SOCIAL!

KSNA is on Social Media!

LIKE US ON FACEBOOK
www.facebook.com/KansasStateNursesAssociation

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