

NURSING IN ACTION

STORIES FROM RUSH NURSING STUDENTS,
EDUCATORS, CLINICIANS & RESEARCHERS

Her PhD Research Started a **FIGHT AGAINST SEX TRAFFICKING**

DAWN BOUNDS REVEALS HOW YOU CAN HELP

IT'S IN THE DATA

HOW THE NEWEST
ROLE IN NURSING
IS REDUCING
MEDICAL ERRORS

ILLUMINATING
THE SHADOWS
OF ADDICTION

Why TV dramas
get it wrong

**THIS IS
REAL LIFE
IN THE ER!**

THE ETHICS OF
**LIFE AND
DEATH**

**MINUTES
COUNT
IN THE
NEURO ICU**



Located in Chicago, the highly ranked Rush University College of Nursing prepares students to advance the quality of patient care and nursing practice. Our graduates are poised to become leaders with a focus on improving health outcomes whether at the bedside, in the community, in a research setting, or directing an organization.

These outcomes emanate from Rush University's integration with a nationally recognized academic medical center; Rush University Medical Center provides a rich environment where students of nursing, medicine, graduate studies and allied health sciences live and learn in an interdisciplinary and dynamic setting.

COVER

Pictured: Dawn Bounds

Photo credit: Heather Woytus/©Motiv8 Agency

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TABLE OF CONTENTS

02

AN INVITATION TO INNOVATE WITH US

Marquis D. Foreman, PhD, RN, FAAN

03

REAL NURSING STORIES: LIFE IN THE ER

Perhaps it's not exactly like TV, but there's still plenty of drama.

06

HOW CLINICAL NURSE LEADERS ARE TRANSFORMING HEALTH CARE

Seeking to reduce medical errors and improve patient safety.

08

HOW TO MAKE A DIFFERENCE: PUBLIC HEALTH NURSING

"Become the change you want to see in the world."

10

ILLUMINATING THE SHADOWS OF ADDICTION

The interesting life of a nurse researcher.

20

Why are so many young athletes suffering knee injuries?



13

40 UNDER 40: EMERGING NURSE LEADERS YOU NEED TO KNOW

13 women from Rush awarded the top "40 Under 40" in Illinois.

16

OUR COVER STORY: HER PhD RESEARCH STARTED A FIGHT AGAINST SEX TRAFFICKING

How do you solve a societal problem no one wants to talk about?

20

NURSES MAKING AN IMPACT: REDUCING SCHOOL ATHLETE INJURIES

In the U.S., girls suffer serious knee injuries at an alarming rate.

22

3 CARING NURSES MAKING A DIFFERENCE IN THE LIVES OF OLDER ADULTS

Nurse practitioners helping the aging live and thrive.

24

REAL NURSING STORIES: LIFE IN THE LABOR AND DELIVERY UNIT

Moments of tension followed by moments of pure joy.

26

THESE NURSES HELP SAVE THE LIVES OF STROKE PATIENTS

At the forefront of revolutionary stroke care.

28

NURSING ON THE FOREFRONT: THE ETHICS OF LIFE AND DEATH

Nurses grapple with ethics as they weigh treatment protocol versus outcomes.

28

When caring for high-risk patients, nurses grapple with ethical dilemmas.



30

WHAT YOU CAN DO TODAY TO PREVENT OSTEOPOROSIS

Here's how to safeguard the strength and health of your bones.

32

HOW NURSES ARE FIGHTING THE OBESITY EPIDEMIC IN PREGNANT WOMEN

Obesity during pregnancy carries severe risks for both mother and baby.



MARQUIS D. FOREMAN

“We want to share the diversity of the nursing experience.”

An Invitation to Innovate with Us

These days, we hear a lot about innovation, particularly in health care. But explaining what innovation “looks like” in a rapidly changing health care environment can be difficult, even for those of us in nursing education.

To me, innovation is about creating change that matters in the lives of every individual we impact, including our colleagues, our students and of course, our patients.

At Rush University College of Nursing, innovation is part of our heritage, which spans more than a century. Today, we are still making history as one of the nation’s top nursing programs. But rankings tell little about the true nursing experience at Rush. That is why we want to share these real-life stories from our students, faculty and alumni. Each nurse profiled here understands that nursing is as much about perseverance and partnership as it is about care and compassion.

In fact, one of the best ways to understand the vital role that nurses play in the transformation of our health care system is by living the experience of nurses themselves. In this publication, we highlight just some of the ways that nurses are making a difference in education, research and practice. Some are focused on reducing disparities in care, while others are leading advanced research to improve quality and safety. Some are guiding the next generation of nurses in an evolving health care landscape, while others are breaking down the barriers that have impeded patients from receiving the care they need.

Through these personal stories, we want to share the diversity of the nursing experience and describe how nursing leaders are using their talent and acumen to improve health care education and delivery.

Despite the different ways in which these highly engaged leaders apply their skills, they share one quality in common: a commitment to lifelong learning. At Rush, we believe some of the most valuable learning comes from collaborations, whether they are across functions or institutions.

If you would like to partner on any of the initiatives described in the stories here, please contact me via Twitter, @RushNursingDean. I would love to hear your ideas and feedback.

On behalf of all of us at the College of Nursing, I hope you enjoy these stories about nursing in action in our classrooms and communities and are motivated to share your own successes in the future.

Marquis D. Foreman, PhD, RN, FAAN
John L. and Helen Kellogg Dean of Nursing

 @RushNursingDean



Real Nursing Stories: LIFE IN THE ER

by **Lisa Jevens**

The real life of an emergency room nurse might not be exactly what's depicted on TV, but there can still be plenty of drama.

Everything from birth to death comes through the door, and nurses are the ones who manage every step with hands-on care. An ER nurse never knows what to expect, yet he or she must handle everything and everyone quickly and effectively while acting as the “eyes and ears” of the attending physicians.

Adam Spurlock, DNP, APN, AGACNP-BC, CNL, works as a Nurse Practitioner in the Emergency Department at Rush Oak Park Hospital in Oak Park, Illinois. Spurlock knew he wanted to work in the fast-paced environment of the emergency room as soon as he had his first rotation there.

“I liked the constant turnover and change; the inability to plan your day. It just clicked,” he says.

While working in the ER for five years, Spurlock earned a Doctor of Nursing Practice (DNP) degree at Rush University College of

Nursing. This degree helped him assume a leadership role in the emergency department. “The degree also allowed me to sit for licensure as an Adult-Gerontology Acute Care Nurse Practitioner, which is the next step in the progression of my career.”

“I’m in charge of making sure things run smoothly in terms of staffing, communicating with other departments and helping out with overload,” he says. He basically functions like a medical traffic cop, monitoring the flow of patients’ progress in and out of the department.

ALL IN A
‘DAY’S’ WORK

A typical night — Spurlock works from 7 p.m. to 7 a.m. — starts by taking over for those nurses clocking out. That means taking stock of where patients are in their treatment, discharge or admission process. As the night goes on, hospital staff gets thinner, but the ER can get

busier with more acute cases. There is only one attending physician from 9 p.m. to 7 a.m., and one advance practice provider until midnight or 2 a.m., plus the nurses.

“It’s usually pretty full. We are up and down — there’s not too much sitting. We do get our steps in on our pedometers,” Spurlock says.

ER nurses have a lot of autonomy to make decisions and advise physicians, which is something most people don’t realize, Spurlock says. ER nurses also must be willing to do the dirty work, from cleaning up feces and urine to putting in IVs and drawing blood, along with monitoring the patient’s vital signs. They are also the front line of communication with the patient’s family.

TEAMWORK
IS CRITICAL

David Manno, DO, one of Spurlock’s attending physicians,

says teamwork is essential in the ER, and nurses must be true team players.

“It’s a close work association,” Manno says. “We rely on each other to observe the patient. Often they will see something I might have missed because I can’t be with the patient the whole time. A good ER nurse will alert you to a change in the patient and know how to manage them so you can step away for a minute.”

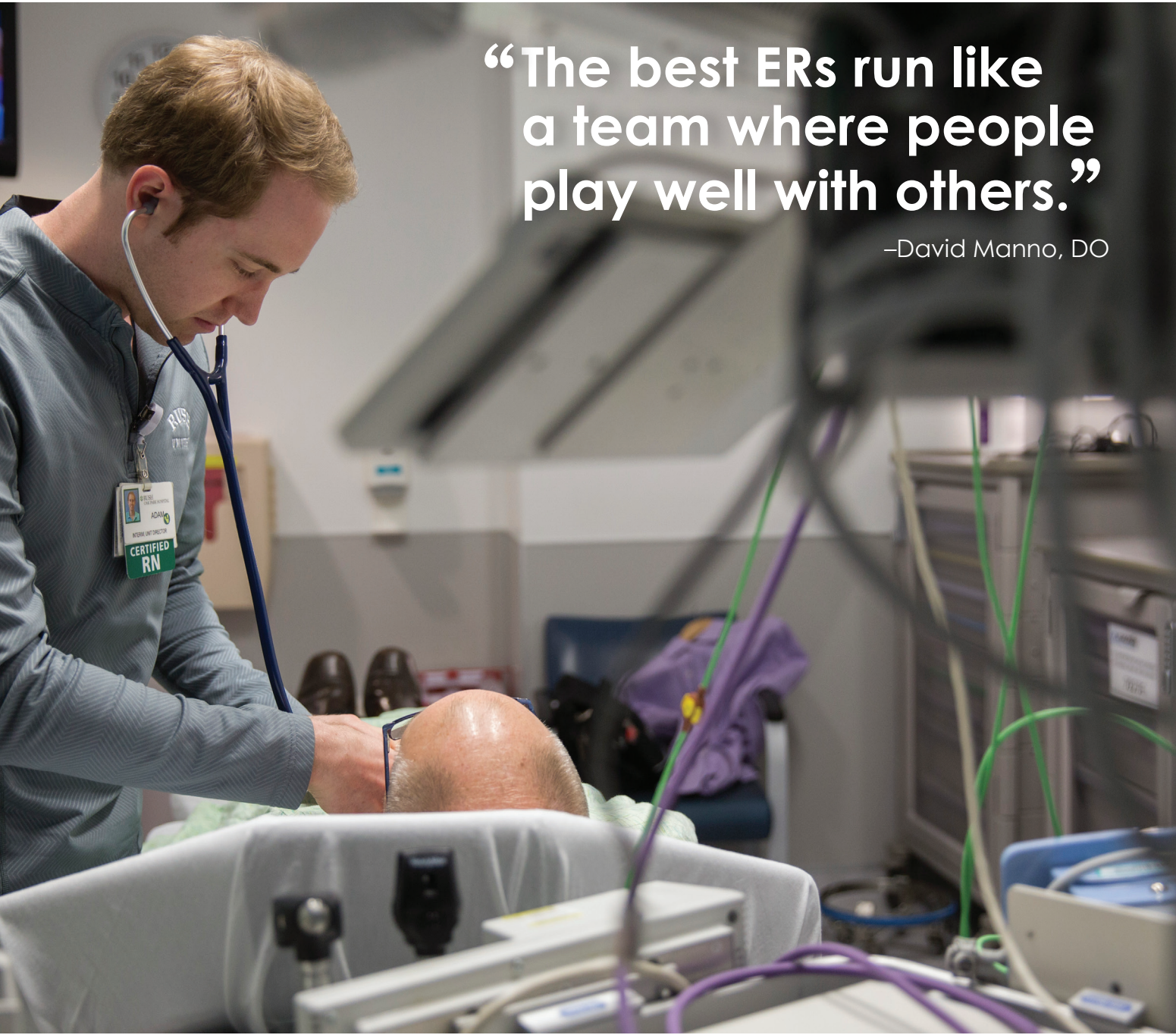
This is important because doctors can be responsible for six to eight patients at any given time, Manno says.

“The best ERs run like a team where people play well with others,” he says. “A good ER nurse must be smart, adaptable and able to handle a large amount of stress. We see people at their worst, and we work in an environment where nobody’s happy because nobody makes an appointment to come to the ER.



“I liked the constant turnover and change; the inability to plan your day.”

ADAM SPURLOCK, DNP, APN, AGACNP-BC, CNL
Nurse Practitioner in the Emergency Department
Rush Oak Park Hospital
@AdamSpurlockRN



“The best ERs run like a team where people play well with others.”

—David Manno, DO

A good ER nurse must have a thick skin to take the abuse that is laid on by patients sometimes.”

Manno is not just speaking figuratively. Spurlock’s shift often sees intoxicated patrons from nearby bars after closing time, often accompanied by police.

“They can cause a ruckus,” says Spurlock, who has been assaulted by angry patients. In those situations, he follows crisis intervention procedures and attempts to de-escalate the situation — and, of course, calls security.

“That’s why I like my job, because it’s not boring,” Spurlock says.

“Even if you’ve been here for 20 years, you think you’ve seen everything and you haven’t,” Manno adds. “You’re always learning.”

“We see people at their worst, and we work in an environment where nobody’s happy because nobody makes an appointment to come to the ER.”

—David Manno, DO

How Clinical Nurse Leaders are TRANSFORMING HEALTH CARE

What do you do when a report by The Institute of Medicine calls out the egregious number of medical errors and lapses in patient safety?

by Laura Lambert



BETH-ANNE CHRISTOPHER, MS, RN, CNL leads an interprofessional team strategy meeting.

One very successful response to that 1999 report has been creation of the Clinical Nurse Leader (CNL) — which combines the personal relationship of a bedside nurse working on a single unit with the leadership qualities needed to run a team, and the advanced knowledge of a master’s-level nurse who can put evidence-based studies into practice. The graduate program in Clinical Nurse Leadership became the first new nursing practice concept in more than three decades.

These highly skilled nurses serve as the nexus for all the various specialists and team members caring for a patient, to lessen miscommunications and lapses in care and improve patient outcomes.

“Most of the safety issues around medicine are results of poor communication,” explains Rebekah Hamilton, PhD, CNL, RN, FAAN, assistant dean for generalist education at Rush University’s College of Nursing, who is herself certified as a CNL.

SUCCESS IN CHICAGOLAND

Some early success with the one-CNL-per-unit model came from the Veterans Administration, which began a pilot program in 2004. It worked so well that in 2011, the Veterans Health Administration set out to have the CNL model in place across all of its sites by the end of fiscal 2016. Meanwhile, the CNL model spread and has been particularly well-embraced in smaller community settings, like Rush Oak Park Hospital, located just outside of Chicago, explains Lola Coke, PhD, ACNS-BC, RN-BC, an associate professor at Rush University College of Nursing.

In fall 2012, Rush Oak Park Hospital hired its first cohort of CNLs in the hospital’s 24-bed telemetry unit (telemetry nurses use special equipment and data to track vital signs for patients needing constant monitoring).

“The graduate program in Clinical Nurse Leadership became the first new nursing practice concept in more than three decades.”

The CNLs charge was to meet with new patients and their families to explain their role as point-person, run the morning rounds, serve as the lead for the unit’s interdisciplinary health care teams, champion patient education and facilitate all transitions of care.

FIXING FRAGMENTED CARE

“We really fulfill a need,” says Denise Wienand, MEd, MSN, CNL, RN, the CNL liaison at Rush Oak Park Hospital. At the small, nonprofit community hospital, where there are no interns or residents, bedside nurses shouldered much of the burden when it came to coordination of care. The CNLs, Wienand explains, stepped easily into that role.

CNLs also support case managers, who typically handle discharge. “We’re on the unit,” Wienand says. “We’re their eyes and ears.”

Seeing, hearing, and perhaps most importantly, communicating what’s happening with each patient is one of the most crucial roles for a CNL.

The CNL is the one who fields and sorts information and then communicates it to the right person, explains Hamilton.

GETTING RESULTS

“There’s not a lot of research — the role is so new,” Wienand explains, which is something this generation of CNLs is out to fix. In August 2015, Wienand served as lead author of “Implementing the Clinical Nurse Leader Role: A Care Model Centered on Innovation, Efficiency, and Excellence.” In that paper, she and the team showed that all outcomes they measured — average length of stay, incidences of falls, pressure ulcers, central line infections and urinary tract infections — decreased after Rush Oak Park Hospital’s trial run with



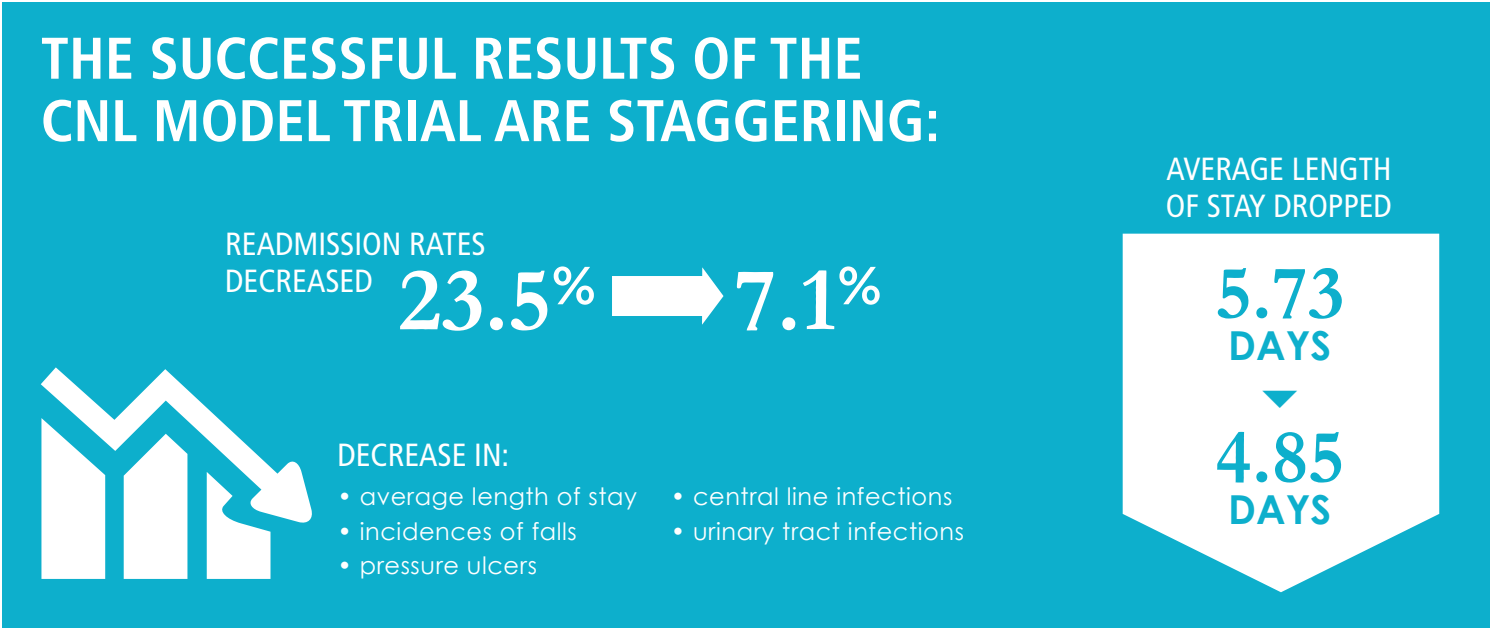
The CNLs at Rush Oak Park Hospital improve care by leading and coordinating the team.

the CNL model. Readmission rates decreased from 23.5 percent to 7.1 percent. Average length of stay dropped from 5.73 days to 4.85 days. Staff satisfaction improved, as did their knowledge.

And these published outcomes are crucial to the future of CNLs. “Hospitals don’t change unless

they have data,” Coke explains, and data from the very people who are shaping a new model of health care is key.

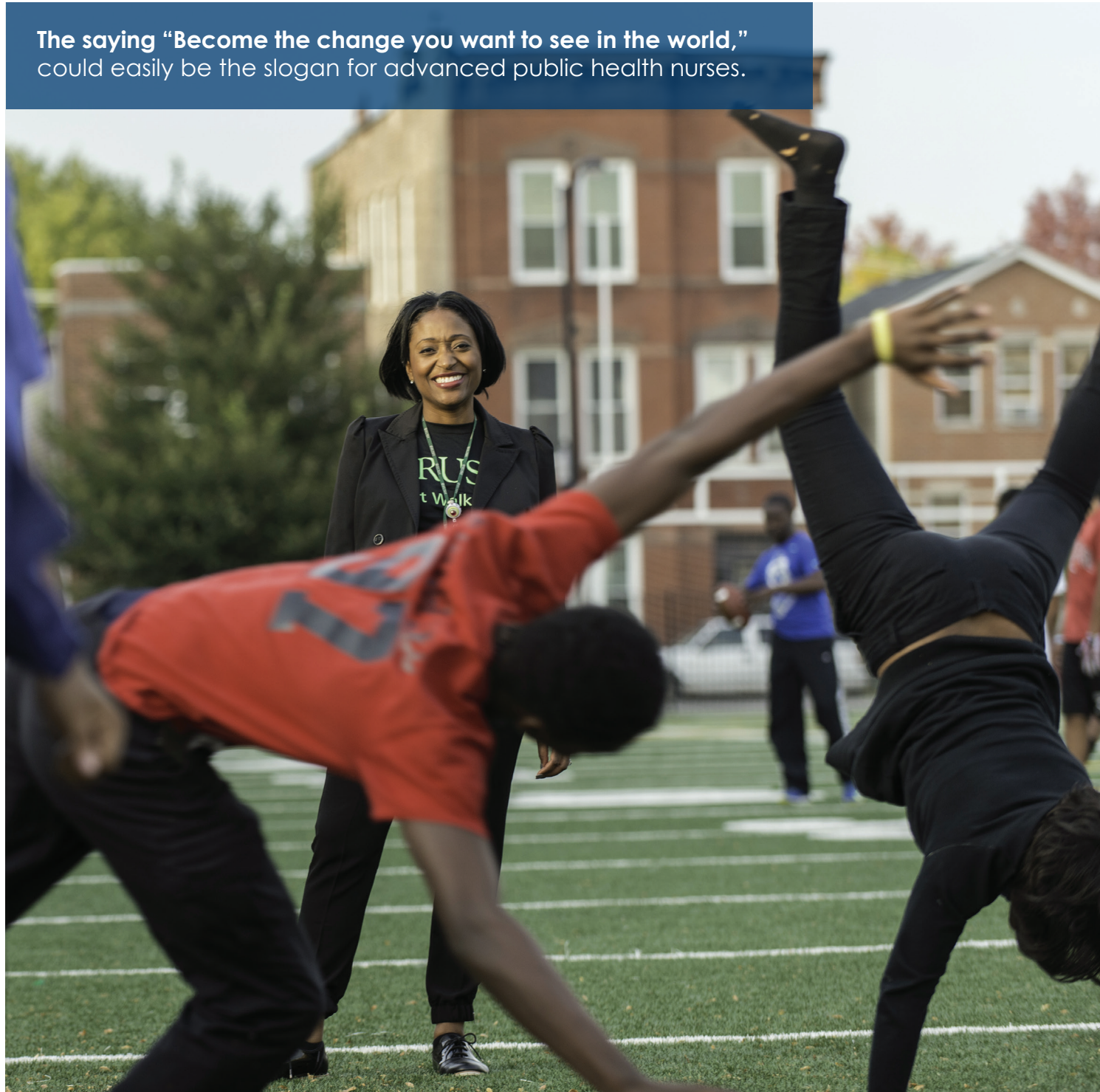
Adds Hamilton, “If you want to sustain a change in a health care setting, that has to come from the bottom up, from the people who are going to do the work.”



How to make a difference: PUBLIC HEALTH NURSING

by Lisa Jevens

The saying “Become the change you want to see in the world,” could easily be the slogan for advanced public health nurses.



Whether developing crisis plans, setting citywide health policy or lobbying legislators, their mission is to create systematic ways to make communities and the people who live in them healthier.

For nurses who want to change the system from within as leaders in their field, the doctor of nursing practice (DNP) degree with a concentration in advanced public health nursing is excellent preparation, says Susan Swider, PhD, professor and director of the Advanced Public Health Nursing (APHN) program at Rush University School of Nursing in Chicago, Illinois.

STUDENT-DRIVEN CONTRIBUTIONS

As part of their graduate work, students in the APHN program research common health problems that have a significant impact in certain communities, such as asthma, teen pregnancy or sports-related concussions. Then they develop interventions to address them, and evaluate their effectiveness.

For example, one graduate looked at data that indicated her state had an increase in sexually transmitted infections, Swider says. “She looked into the literature to see what had been done to help young adults. She developed an intervention in one county for when people came in for STI testing that involved talking about risky behaviors. She did some marketing to encourage people to get into the clinic more often, and then figured out a way to measure its success.” The state plans to replicate this program in other counties.

Students also are taught how to construct a budget, pitch a program to a board of health, train the nurses and other public health staff who will carry out the intervention — and so on.

“It’s all about looking at a population and figuring out what to do, then doing it,” Swider says.

FOUNDATION OF LEADERSHIP

Cathy Catrambone, PhD, RN, associate professor at Rush University School of Nursing, calls this being a “system thinker.”

“Nurses are uniquely qualified to do this because they already have a comprehensive view of the patient and the science,” she says. “All they need is to be able to look critically at the system that they’re in, and analyze data and apply current research. They’ll see what changes need to be made, and they’ll be the person to help lead those changes.”

This is how public health nurses tackle the major epidemics that make headlines, such as the Zika virus. In those cases, nurse leaders might assemble a team of key people, help set policy and action plans and design metrics to measure outcomes, Catrambone says.

Leadership training is a big part of the Advanced Public Health Nursing degree.

“My graduate education prepared me to be a leader,” says Catrambone, who earned a PhD at Rush. In addition to teaching, Catrambone was elected president of the Honor Society of Nursing, Sigma Theta Tau International in 2015 — an international nursing organization with 135,000 members in 91 countries. Its mission is advancing world health and celebrating nursing excellence in scholarship, leadership and service.

“My graduate degree in nursing is what prepared me to move an organization forward strategically,” she says.



Sue Swider: first row, far left (gray jacket). Public health students and faculty from Rush presenting at the American Public Health Association (APHA) conference in Chicago. The APHA hosts 13,000 public health professionals from across the country.

Advanced degree public health nurses are also uniquely qualified to lobby legislators and inform the public about the health impacts of public policies, across all sectors of government and society.

For example, as a Board member Catrambone worked with the Respiratory Health Association in Chicago for years to make Chicago and Illinois smoke free in public places. She is currently working for smoke-free parks and housing, and focusing on efforts to reduce youth smoking rates.

In 2011 Swider was appointed to President Obama’s Advisory Group on Prevention, Health Promotion, and Integrative and Public Health headed by the U.S. Surgeon General. Its mission is to advise on the best ways to implement the National Prevention Strategy — a guideline released in 2011 designed to increase the number

of Americans who are healthy at every stage of life.

PURSuing PUBLIC HEALTH

If you’re an RN considering graduate school, how do you know if Advanced Public Health Nursing is right for you?

“If you’re a person who has a particular area in which you want to make a difference by bringing the best of science from the practice setting and implementing change to improve individual health and the health system, you would be a good candidate,” Catrambone says.

The three-year, part-time program is taught online, so nurses across the country can participate. Students do clinical work in their own community. Rush University School of Nursing’s DNP program was ranked fifth in the country by U.S. News & World Report, 2017 edition. 📖

“My graduate degree in nursing is what prepared me to move an organization forward strategically.”

—Cathy Catrambone

 @CathyCatrambone

ILLUMINATING THE SHADOWS OF ADDICTION

The interesting life of a nurse researcher by Lindsey Malkus



Addiction. Addict. Drug abuse.

These loaded words carry serious social stigma – a stigma Julie Worley, PhD, FNP, PMHNP, a nurse researcher and assistant professor at Rush University's College of Nursing, is fighting to change.

So Worley, who co-authored the study “Women Who Doctor Shop for Prescription Drugs,” published in 2013 in the Western Journal of Nursing Research, is careful to use terms such as “substance use disorder” instead. Although even that language is inadequate, she says. “There is no term for ‘prescription drug use disorder,’ so I do at times use the term ‘prescription drug abuse’ because there is no alternative.”

DIVERSE EXPERIENCE

Such careful consideration and respect for her subjects and what they deal with is partly a product of Worley's impressive, diverse and extensive experience. She holds a PhD and dual certifications as a family nurse practitioner and a psychiatric mental health nurse practitioner. She's worked in home health, public health, medical surgical nursing and pediatrics, practiced in a jail and two inpatient psychiatric units and has had her own private practice in psychiatry, all of which give her a unique perspective on the behaviors of both patients and medical professionals.

But it was her experience prescribing medicine that led Worley to study “doctor shopping,” a term used when patients with substance use disorders obtain multiple prescriptions for controlled substances from various medical providers – any health care professional who prescribes medicine. While in private practice, Worley encountered several doctor shoppers. So when she was deciding on her research trajectory for her PhD, the subject was a natural fit.

IMPORTANT RESEARCH

Because gender differences exist everywhere, including in prescription drug abuse



“Julie is tireless in educating professionals about what they can do to improve substance use services.”

–Kathleen R. Delaney

@KathRDelaney

and doctor shopping, Worley wanted to understand women's unique experiences. But she first needed to recruit study participants, a task that proved difficult and required ingenuity. “I put up fliers and I did all these other things,” Worley says. “But none of that worked.” So she began attending Narcotics Anonymous (NA) meetings.

“I would go to a meeting, and they'd let me introduce myself, then afterward somebody would maybe come up to me,” Worley says. “But if I didn't go to meetings I didn't get any participants.” It was a long but worthwhile process; she attended more than 15 NA meetings and eventually signed up 14 participants.

BRAVERY AND COMPASSION

“To understand and intervene in a phenomenon, it's important to understand the experience of the people involved,” Worley says about her

research. So once she found her subjects, she immersed herself in their world, which put her in difficult and sometimes dangerous situations. At Narcotics Anonymous, she discovered that men often attended meetings to pick up women. And despite announcing herself as a researcher, she became the target of unwanted attention on several occasions. Some attendees also used meetings to buy and sell drugs, which brought a police presence; people would sometimes be stopped coming in to a meeting.

Worley's work outside of meetings was more dangerous but also key. She conducted interviews with participants in locations ranging from an empty office building to a halfway house. Alone and sometimes in unsafe areas at night, she put herself at risk to gain her subjects' trust — risks that paid off. “They even invited me to go to some of their gatherings,” she recalls. “I didn't go, but I really became a part of their community.”

HAVING AN IMPACT
Going that extra mile provided an abundance of research data and helped Worley identify key themes and strategies health care professionals can use to help identify and stop doctor shopping and provide better care for people struggling with this issue.

Since conducting her initial research, Worley has published several other articles on this topic and spoken at conferences to help people become more compassionate toward and better understand those suffering from substance abuse. For Worley's second study, in 2015, she led a multidisciplinary team of researchers and conducted Skype interviews with psychiatric prescribers across the country. Understanding both sides of doctor shopping enabled Worley's team to start developing a mobile app intervention

to further help health care professionals identify and prevent prescription drug abuse. In addition, Worley also works with patients with substance use disorders at a treatment facility in Chicago. All those efforts and dedication earn praise from colleagues. "Julie cares broadly about improving treatment for individuals with substance use issues," says Kathleen R. Delaney, PhD, PMHNP-BC, professor at Rush University College of Nursing. "She is tireless in educating professionals about what they can do to improve substance use services."

While Worley is pleased with the increased attention to prescription drug abuse, she emphasizes there's still work to be done. "Having a substance use disorder is a chronic illness similar to diabetes or high blood pressure," she says. "People with substance use disorders should not be treated any differently." 📌



JULIE WORLEY, PhD, FNP, PMHNP,
Nurse Researcher and Assistant Professor
Rush University College of Nursing
@WorleyJulie

“People with substance use disorders should not be treated differently.”
—Julie Worley



NURSING STUDENTS AMONG FIRST IN NATION TO RECEIVE NALOXONE TRAINING

Every day, 44 people die of an opioid overdose, which recently surpassed motor vehicle accidents as the leading cause of accidental death in the United States. Naloxone, an opioid antagonist administered as an injection or nasal spray, can reverse an overdose.

As part of academic nursing's ongoing efforts to combat prescription drug and opioid abuse across the United States, Rush University College of Nursing has committed to educating its advanced practice registered nursing (APRN) students on the Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain. The commitment was featured in a White House fact sheet as part of the White House Champions of Change event on Advancing Prevention, Treatment and Recovery.

Rush recognizes that opioid abuse is a pressing public health crisis, and it is critical that APRN students receive education on current standards.

The College of Nursing's opioid education efforts includes a naloxone training session for all nursing students and faculty, organized by Worley in conjunction with the Chicago Recovery Alliance. Worley has become a group trainer for this life-saving intervention, and has been asked by regional nursing organizations to train their members.

“Opioid overdoses are becoming more common and it could happen that anyone could come across someone overdosing in a public area,” Worley says. “This overdose training will provide the knowledge and skills so that our students and faculty can take appropriate action if needed.”

40 40

EMERGING NURSE LEADERS YOU NEED TO KNOW

RUSH UNIVERSITY MEDICAL CENTER IS WIDELY RECOGNIZED AS A LEADER IN NURSING EXCELLENCE, AND THAT LEADERSHIP STARTS EARLY.

The Illinois Nurses Foundation and the Illinois Healthcare Action Coalition recently chose 13 nurse alumni and nursing faculty members (12 featured below) from Rush for the organization's 40 Under 40 Emerging Nurse Leader Awards for 2015 and 2016. Only one other institution in Illinois had more than one nurse who received the award, which was given to honor leadership and commitment well beyond the nurses' years.



FAWN A. COTHAN, PhD, RN, GCNS-BC
Assistant Professor, Adult Health and Gerontological Nursing
Rush University College of Nursing

As a gerontological nurse researcher, Cothran is working to help African-American caregivers caring for persons living with dementia. The goal of her program of research is to develop culturally tailored interventions to promote caregivers' physical and mental health, and in turn improve the quality of care for persons living with dementia.



JENNIFER M. GRENIER, MSN, RN-BC
Director of Nursing, Acute In-Patient Rehab
Rush University Medical Center

Grenier sees the empowerment of her staff of nurses as a direct way to advocate for higher levels of patient care. She has spearheaded many initiatives, including the creation of a daily report card for patients and families outlining the treatment plan and providing needed education. Most recently, Grenier has taken the lead on Rush Oak Park Hospital's surplus project, which donates food not used at the hospital to a local food pantry. Grenier is also completing her DNP degree in Systems Leadership at Rush.



MICHELLE HEYLAND, DNP, APN
Nursing Faculty Member, Community, Systems and Mental Health Nursing
Rush University College of Nursing

Just one year after graduating as a nurse practitioner, Heyland assumed a leadership role at a progressive community mental health organization, Turning Point. There, she helped create a crisis center that supports individuals through difficult times while minimizing emergency department visits and psychiatric hospitalization. The model, called the Living Room, served 87 individuals during 228 visits its first year. People were diverted from making emergency department trips on 213 occasions, representing a savings of approximately \$550,000 to the state of Illinois.



AMBER S. KUJATH, PhD, RN
Assistant Professor, Adult Health and Gerontological Nursing
Rush University College of Nursing

▼
Kujath has served as a director since 2011 and is a past president (2014-2015) of the Orthopaedic Nurses Certification (ONC) Board. She has been an item writer for the ONC exam and served on the re-certification committee. She also serves locally as a chapter officer and nationally on the research committee for the National Association of Orthopaedic Nurses. Her research and service also includes helping people with Type 1 diabetes. She has been serving as a volunteer with the American Diabetes Association regional camp committee, and for the past 10 years as health team staff at the Triangle D residential summer camp for children 9 to 13 years old with Type 1 diabetes.



NICOLE MURPHY, BSN, RN, CCRN
Surgical Intensive Care Unit Nurse
Rush University Medical Center

▼
After a long-time surgical intensive care unit nurse passed away due to cancer, Murphy's work with the SICU Recognition and Morale Committee helped create the Nurses Helping Nurses Foundation to support nurses and their families in times of need. The foundation helps nurses financially, memorializes nurses who have died and supports those who have suffered losses.



MONIQUE REED, PhD, RN
Assistant Professor, Community Systems and Mental Health Nursing
Rush University College of Nursing

▼
Reed's research work focuses on identifying interventions to address the high rates of obesity in African-American daughters and mothers, as well as identifying best teaching strategies for nursing faculty to use in teaching students culturally competent care. She collaborates with experts in the disciplines of nursing science, physical activity, nutrition and psychology as well as key community informants. Her research is informed by over 10 years of work with community based programs serving the needs of the underserved in the Chicago area. Reed also serves as a faculty member liaison with a clinic based at an inner city Chicago Public School.



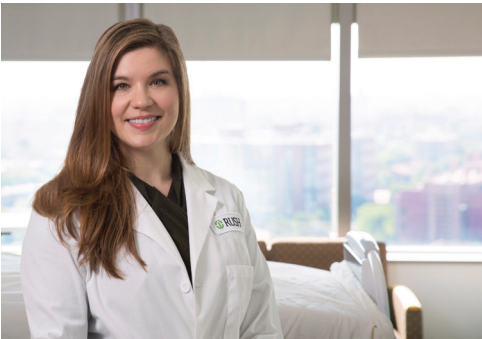
CHRISTINE TATOM, MSN, RN, CCRN
Intensive Care Unit
Rush Oak Park Hospital

▼
Tatom has made her mark in the community with her volunteer work for the Village of Oak Park and Rush Oak Park Hospital, where she holds several committee leadership roles. She dedicates her time to the Oak Park-River Forest Food Pantry and the village's Emergency Response Team and Medical Reserve Corps. In addition, she spends time educating new nursing graduates.



NATALIE VELAZQUEZ, RN
Assistant Unit Director and Operating Room Nurse
Rush University Medical Center

▼
Velazquez started a chapter of the Association of Perioperative Registered Nurses at Rush and has been president of the chapter for more than a year. She has a passion for volunteer work, initiating a winter coat and mittens drive for children in need. She also is quick to act: Velazquez recently took initiative in a code blue — an alert at a hospital when a patient is in need of resuscitation — and performed chest compressions on a patient.



SARAH LIVESAY, DNP, RN, ACNP-BC, ACNS-BC
Assistant Professor
Rush University College of Nursing

▼
Livesay began her career as a neuroscience nurse, a specialty she has maintained for the past 14 years. She has expertise in stroke and neurocritical clinical care, as well as building and evaluating neuroscience service line and clinical programs. Over the past five years, Livesay has worked as a field reviewer for The Joint Commission, evaluating primary and comprehensive stroke programs. She speaks nationally on a variety of topics including stroke and induced hypothermia.



SARIA LOFTON, PhD, RN
Clinical Assistant Professor
College of Nursing , University of Illinois at Chicago

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Lofton's work focuses on socio-cultural determinants of food choices in African-American youth and the impact of community food environments on fruit and vegetable consumption in African-American families. Lofton has led several obesity prevention initiatives, including a salad bar and school garden, while working as a certified school nurse in the Chicago Public Schools. She is currently teaching in the Advanced Population Health Program at UIC, and has also served on various committees related to school nursing, school health and nutrition. Lofton graduated from Rush in 2015 with a PhD in Nursing Science.



ANGELA MOSS, PhD, MSN, APN-BC, RN
Director of Faculty Practice & Assistant Professor
Rush University College of Nursing

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Beginning in 2009, Moss developed an innovative, nationally recognized nurse-managed primary care delivery model in a worksite setting. The model has been replicated successfully across diverse settings and patient populations. Concurrently, Moss developed a program of research focusing on community based, nurse-managed models of primary care. Recently Moss was the primary author on a National Organization of Nurse Practitioner Faculty (NONPF) Faculty Practice Toolkit. In her current role, Moss collaborates on and oversees over 25 Faculty Practice community partnerships across Chicagoland and Northwest Indiana, and over 40 nurse and nurse practitioner clinicians.



RACHEL REICHLIN, MPH, MSN, RN, CTN-B
Public Health Nurse & Manager of Care Management
Cook County Health and Hospitals System

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Reichlin brings an equity lens to her work and leverages her role as a bedside nurse and public health practitioner and researcher to collaborate on innovative ways to address health inequities and promote social justice. She has conducted community-based participatory research projects in urban immigrant communities in Chicago as well as with asylum-seekers in Israel. She is experienced and passionate about operationalizing programs that improve outcomes for the justice involved population. Currently, Reichlin oversees the Care Management and Disease Management program for a public Medicaid Managed Care health plan in Cook County, and partners with other entities in community health assessments. She is an active member of Health and Medicine Policy Research Group's Board of Directors and co-founder of Nurses for Social Justice. Reichlin is an alumna of Rush College of Nursing.

HER PhD RESEARCH STARTED A FIGHT AGAINST SEX TRAFFICKING

by Lindsey Malkus

HOW DO YOU SOLVE A SOCIETAL PROBLEM NO ONE WANTS TO TALK ABOUT? This is the question that Dawn Bounds, an assistant professor at Rush University College of Nursing, faced when beginning her research on the underground world of commercial sex trafficking. It's a simple question without an easy answer.

Sex trafficking refers to someone using force, fraud or coercion to cause a commercial sex act with an adult or cause a minor to commit a commercial sex act.



IDENTIFYING THE PROBLEM

Bounds, PhD, PMHNP-BC, first became concerned about the world of sex trafficking of minors after attending a forensic nursing conference’s presentation on the commercial sexual exploitation of children. With 16 years of experience working in psychiatry and mental health, and a primary focus working with adolescent girls, the presentation struck a chord with her.

“Systems set up to care for these young people were failing them by criminalizing their behavior — responses to trauma,” she remembers. “I felt that this area was under-researched, but of particular importance to the girls I was working with.”

Bounds recalls that while working with teenage girls at the Cook County Juvenile Detention Center and in Rush’s school-based health centers in Chicago, “I often heard about their traumatic experiences and subsequent relational challenges. The relationships they described were often unhealthy — and with boys much older than them.”

This is when she realized that the mental health, school and juvenile justice systems set up to care for these young people were failing them, and that she could do something to help.

Bounds read through 1,300 posts from a popular website where men involved in commercial sex share information.

SHINING A LIGHT ON THE ISSUES

To better understand the commercial sex industry, Bounds analyzed online conversations from a popular website where men involved in commercial sex shared information. She read through over 1,300 posts looking for patterns and hoping to better understand how the men’s repetitive posts shaped discourse about commercial sex.

What she found went against some preconceived notions.

“It has been suggested in the past that men who buy sex may not know that they are buying sex from vulnerable girls and women,” Bounds states. “My research findings, however, suggest that they do know and use the vulnerability of girls and women to exploit them for (the men’s) own personal gain.”

This finding surprised her. She recalls men exchanging insider tips on women, meant to capitalize on their possible weaknesses. Bounds found it exceptionally shocking to read comments such as, “She’s recently divorced and has kids to take care of.” There were also comments about women with disabilities, substance abuse issues, and who looked very young.

While she admits that much of what she read moved her to anger and frustration, she also stresses the importance of understanding the communication between men who deal in the commercial sex industry. “The significance of studying discourse is that discourse has the power to influence beliefs, relationships and, ultimately, actions.”

“Human sex trafficking is the most common form of modern-day slavery. Estimates place the number of its domestic and international victims in the millions, mostly females and children enslaved in the commercial sex industry for little or no money.”

–FBI Law Enforcement Bulletin

FINDING A SOLUTION

Bounds’ actions and research have led to a wider knowledge and discussion of this once little-known world. Her PhD dissertation, “The Complexities of the Demand Side of the Online Commercial Sex Industry,” and published article, “Commercial Sexual Exploitation of Children and State Child Welfare Systems,” have helped shed light on the dark and dangerous world of sex trafficking.

Wrenetha Julion, PhD, MPH, RN, FAAN, Bounds’ academic adviser from her doctoral program at Rush, stresses the value and influence of her work.

“Dawn’s research in sex trafficking is important because it is not only novel and innovative; it can change the life course of vulnerable young people,” Julion says. “Dawn’s work has the potential to save lives and make a sustained impact.”

While Bounds made great strides in drawing attention to this secret world, she is quick to point out that there’s still much work to be done.

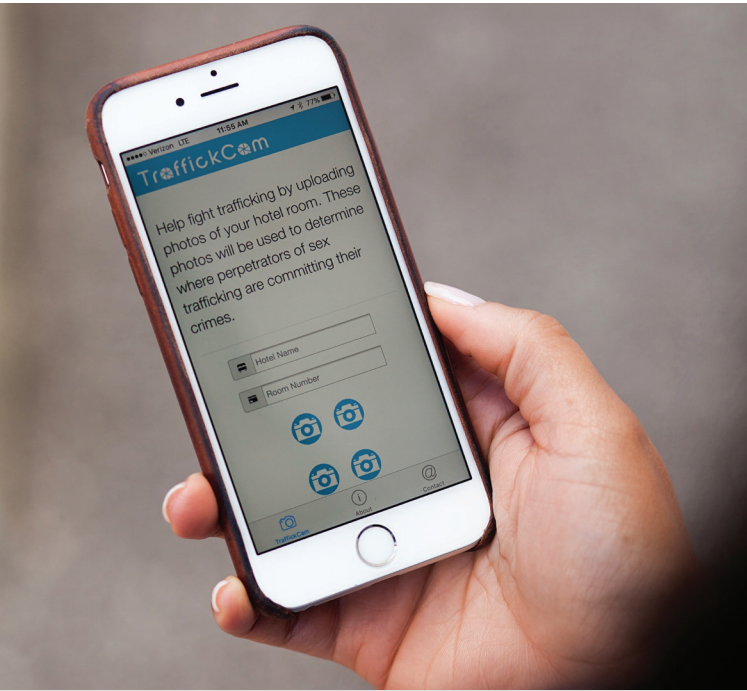
“There are vulnerable people who are being exploited every day,” she says. “I feel morally responsible to challenge injustices that impact basic human rights, particularly those of young people. I believe all adults have a responsibility to protect our youth. We have a long way to go.”

WHAT’S NEXT?

Next, Bounds will be working with The Dreamcatcher Foundation, a Chicago-based organization that seeks to prevent sexual exploitation of at-risk youth and provides education and support for individuals involved in prostitution to help them see alternatives to their current lifestyle. Bounds will be hitting the streets to work with youth who may be vulnerable to trafficking or prostitution. She also hopes to obtain a grant to hire nurses to provide health and intensive case management services to at-risk youth.

Bounds is also partnering with The Runaway Intervention Program, a Minnesota-based organization that serves young runaways and helps them rebuild their lives.

Bounds’ goal through all of her various efforts is to increase mobile street outreach locally, combine street outreach with health care provided by nurse practitioners to make a bigger impact, and eventually help create a nursing center where at-risk youth are at the center of practice, research, and education for transdisciplinary networks of clinicians and community members. 📍



HOW YOU CAN HELP

You don’t have to know a victim to help with this issue. Here are three ways to make a difference.

- 1. IF YOU SEE SOMETHING, SAY SOMETHING.** Trust your gut. If you see anything odd like a massage establishment open in the middle of the night, call the National Human Trafficking Resource Center at 888-373-7888. Its mission is to provide victims and survivors with support and services and to equip the community with the tools to combat trafficking.
- 2. DOWNLOAD TRAFFICKCAM,** a new app that allows you to help fight trafficking by uploading photos of hotel rooms you stay in when you travel. Traffickers often use photos of their victims in hotel rooms as a form of advertisement, assuming authorities won’t identify where the picture was taken. The goal is to create a database of hotel rooms for investigators to match to victim photos. TraffickCam is available for iPhone or iPad from the App Store or for Android from Google Play.
- 3. MENTOR A YOUNG PERSON.** According to youth.gov, 8.5 million youth lack a sustained adult relationship. By taking a young person under your wing and mentoring them, you give them access to your world so they can see the possibilities. Mentoring has been shown to increase high school graduation rates, enhance self-esteem, reduce the likelihood of drug and alcohol use, and more. Reach out to local youth organizations to find mentorship opportunities. Saving even one child is worth it.





Knee Injury Prevention Program (KIPP), is a neuromuscular training program designed to reduce the risk of ACL injuries.

NURSES MAKING AN IMPACT: REDUCING SCHOOL ATHLETE INJURIES

by Lindsey Malkus

Every year, more than 20,000 girls across the U.S. suffer serious sports-related knee injuries — and a Rush University nurse researcher is helping figure out how to prevent that.

Perhaps due to neuromuscular differences, girls are up to six times more likely than boys to injure their anterior cruciate ligament (ACL) during similar sports. An injury can be not only frustrating but have long-term effects on the athletes — even leading to pain and arthritis as they age.

For Debra Chudzik, DNP, RN, BS, at the time a registered nurse studying for her Doctorate of Nursing Practice (DNP) at

Rush University, a desire to help child athletes prevent injuries became a research project and quest, born of her background as a pediatric nurse, a school nurse and as a mother of school-age athletes.

As part of her research capstone for her DNP, Chudzik taught an entire Illinois school district, Orland School District 135, injury prevention using the Knee Injury Prevention Program (KIPP), a neuromuscular training program designed to reduce the risk of ACL injuries.

According to research pioneered by Cynthia LaBella, MD, at Ann & Robert H. Lurie Children's Hospital of Chicago, KIPP exercises reduced ACL injuries

by 80 percent, knee sprains by 70 percent and ankle sprains by 62 percent. Learning of LaBella's success, Chudzik helped implement the program across District 135's physical education curriculum for grades K-8, studied the results and made further recommendations.

THE PATH TO INJURY PREVENTION

Chudzik describes her career pathway leading to her injury prevention efforts as “a nice journey.”

“I was a clinical nurse for the majority of my career. I specialized in pediatric intensive care and worked in a pediatric surgical heart unit. Then I did some

medical sales for a couple of years. Then I was a school nurse,” she says. “That’s about the time I decided to go back to school.”

Chudzik always wanted to teach in a nursing program, and says “everything kind of came together very nicely when I went back for my doctorate.”

Chudzik's diverse background was an asset when pursuing her doctoral degree. “She utilized her nursing degree in a wide range of environments,” says Janice Odiaga, DNP, CPNP-PC, director of the pediatric DNP program at Rush University. “I think her personal and work experiences broadened her approach to her doctoral project.”

DIAGNOSING AN ISSUE

It was this broadened approach that helped Chudzik focus and conduct her research. While she relied on her professional experience in conducting her research, it was her personal experience that guided her topic choice.

“What really drew me to research injury prevention were both my children,” she says. “They’ve been athletes since they were very little, and were always in physically intensive sports.”

When her daughter, a junior high gymnast, had to undergo modified “Tommy John” surgery (a ligament procedure named after the Major League Baseball pitcher) for an injury usually seen in professional athletes, Chudzik knew there was a problem.

“That was one of the defining moments that solidified for me that this is where I needed to focus my research,” she says. “The injury that she had was an overuse injury. The more research I did, the more I saw that young people are developing these debilitating injuries from overuse and overtraining.”

GOING BACK TO SCHOOL

To find her research subjects, Chudzik looked to Orland School District 135, the same district where she'd been a school nurse for more than five years. The principal of Orland Junior High welcomed her back with open arms. “Actually, it kind of escalated,” Chudzik remembers. “My project was to implement the KIPP program into the school system. Originally, that meant one school — one junior high.”

It quickly became clear that Chudzik's research filled a gap in the PE curriculum. Lynn Zeder, assistant superintendent of teaching and learning for District

135, recognized this and gave final approval for the program to be implemented throughout all 11 schools in the district, in all grades (K-8).

“I was just floored by the welcoming,” Chudzik says. “They knew this was good, important research.”

The next step was to train the district's PE instructors in KIPP. Chudzik walked 18 of them through the program, provided background on the benefit and purpose of each of the exercises, distributed laminated cards for easy reference, and then stepped back.

“These instructors are our first line of defense to reach these kids,” she says. “I want this program to be sustainable without me. So I wanted to be as hands off as possible.”

The physical education instructors embraced the program, and Chudzik says they gave valuable feedback for her research.

CHANGING A COMMUNITY

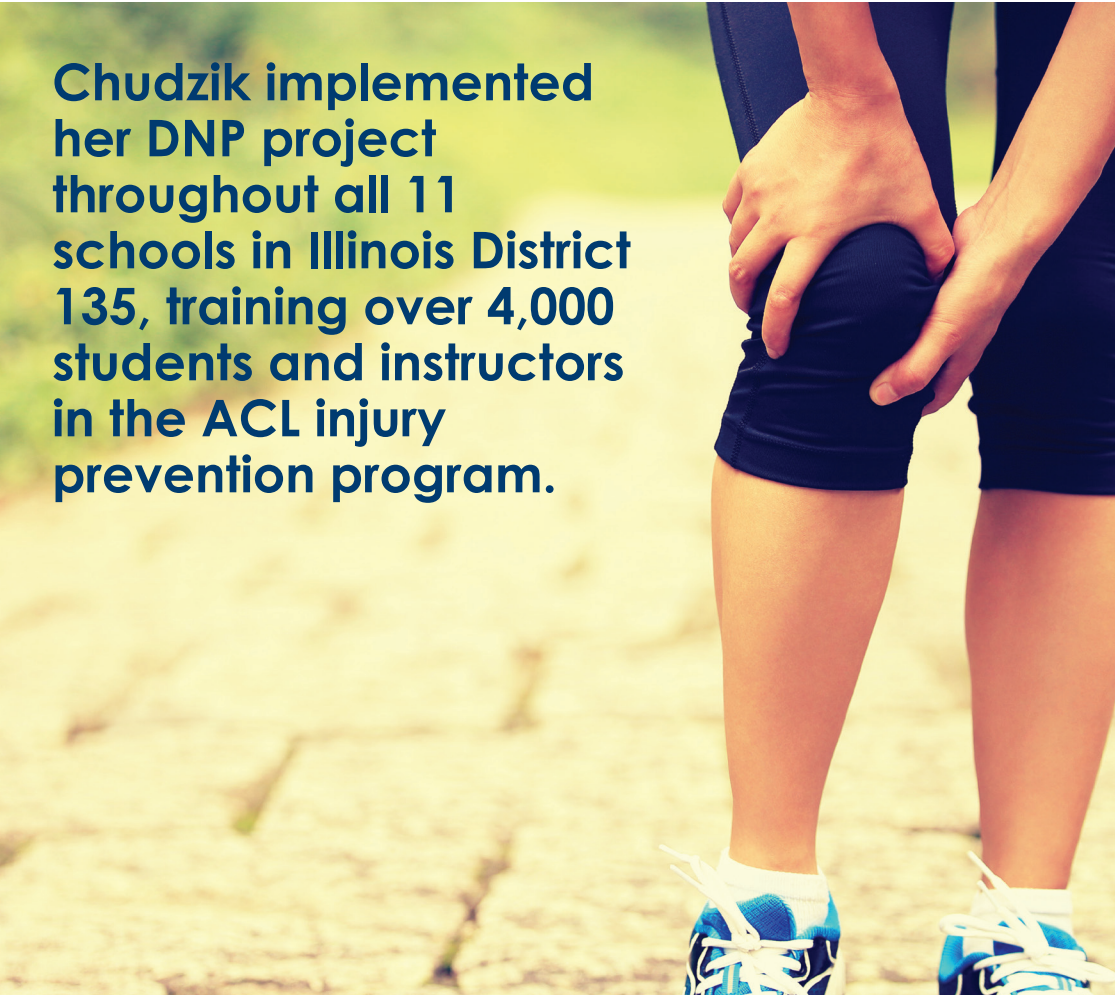
The results showed the importance of this kind of program, but data was somewhat limited due to uneven participation. Chudzik, who is currently working as an adjunct professor at DePaul University, hopes to build on what she's started. “I'm talking with the school district right now to see if we can do a refresher course. Part of what we discovered was that even though the teachers really thought they (the exercises) were important, there was a time element that got in their way.”

Additionally, Chudzik would like to add a record of student injuries. “One of the issues that I had to deal with is that within

District 135 we didn't have a database on injuries. So there wasn't anything to compare against to measure the impact of the program.”

While the impact of Chudzik's research is difficult to fully quantify yet, the benefit is very clear to those who have reviewed the goals and findings thus far. Odiaga reaffirms the importance of this type of research.

“Preventing injuries is key to keeping children and adolescents in the game and active for life,” Odiaga says. “The long-term consequences of these injuries include chronic knee pain, need for reconstructive surgery and extensive rehabilitation. These can be avoided if coaches and physical educators incorporate the KIPP program in their structured warm-up for both gym and sports.”



Chudzik implemented her DNP project throughout all 11 schools in Illinois District 135, training over 4,000 students and instructors in the ACL injury prevention program.



3 CARING NURSES MAKING A DIFFERENCE in the Lives of Older Adults

by Laura Lambert

Weak. Helpless. Unproductive. These stereotypes paint a dismal picture of what it's like to be an older adult — especially in underserved communities. But today, in neighborhoods around Chicago, caring people are stepping forward to help the aging live and thrive. On the forefront of this caring revolution: nurse practitioners.

Here are three Chicago-area nurse practitioners who are making a huge difference in the lives of their oldest patients.

BARBARA HARDT *Nurse Practitioner at Oak Street Health*

“My dreams of being a nurse were about making a difference in people’s lives,” says Barbara Hardt, MSN, AGNP-C, CMSRN. “I felt I would take on the world by becoming a nurse practitioner.”

After graduating from Rush University College of Nursing with a specialty in adult geriatric primary care, Hardt found she was able to make a difference doing home visits on the West Side of Chicago for homebound, bedbound patients. It was rewarding, though very challenging work.

Then, when the opportunity arose to join Oak Street Health, a network of community centers aimed at older adults on Medicare, she jumped at the chance.

“Oak Street was set up to provide exceptional care to older adults in underserved neighborhoods,” Hardt explains.

What does exceptional care look like? “My patients are relatively complex, with multiple co-morbidities (multiple chronic illnesses) and things like drug use,” she explains. “It’s a lot of psychosocial work, especially with older adults — a lot of them want to come in and talk.”

And because talk is valued at Oak Street, appointments can run long — 20 minutes with a health care provider, in addition to 20 minutes with a medical assistant, with some appointments lasting over an hour. “The founders recognize that working with older adults, we have to listen,” says Hardt. “Things take a little longer. They’re more complex.”

Part of that complexity means looking at the whole patient — to understand not just an acute or chronic ailment, but also the senior’s life in context.

“I’m trained first as a nurse — trained to see not just labs or diseases, but the patient, their family, their home life, the grocery stores they have access to, the community they live in and the greatest problems they’re faced with,” says Hardt.

And the care at Oak Street Health is also about creating a space where underserved patients — many of whom haven’t had the most positive experiences with the health care system — actually want to be.

“We feel that we should be someone’s home away from home. You come here for bingo and blood work,” she jokes, then adds more seriously that Oak Street strives to meet all sorts of needs, including being a warming and cooling center in Chicago’s more extreme weather days. “Plus,” she says, “there’s always coffee.”

CHRISTINA GRAHAM *Nurse Practitioner at Symphony of Chicago West*

In hospitals across the country, many older patients are discharged to post-acute care facilities because of complex health concerns (such as diabetes) in addition to whatever acute issue is at hand. Nurse practitioners like Christina Graham, APN, AGPCNP-BC, are the go-betweens, bringing high quality primary care to nursing homes — in this case in partnership with Rush University Medical Center and Rush Oak Park Hospital.

The innovative Rush Coordinated Care program began about four years ago and is currently serving five nursing home facilities across Chicagoland. “I would say that of the five, Symphony Chicago West is probably in the most underserved community,” Graham explains. “On average, 90 to 95 percent of our patients are receiving public aid.”

The program has three goals: to improve the quality of care for patients who leave the hospital and go to post-acute care facilities; to reduce 30-day readmission rates; and to foster relationships with nursing care facilities.

Graham and two other nurse practitioners are employees of Rush Oak Park Hospital, not the nursing homes where they work. “The hospital has established the relationship to improve care,” says Graham. “There are benefits for both parties.”

There are also benefits for the nurse practitioners. “We’re practicing at the top of our scope of practice,” she says.

Particularly at Symphony West, that practice often goes beyond managing chronic conditions.

“I had to learn how to reshape my history-taking skills, reshape the whole visit, to add in all these other considerations on top of the medical issues,” Graham says. Those other considerations are issues like housing, family problems, homelessness, undiagnosed psychiatric issues, alcoholism and other addictions.

What keeps her consistently engaged is the impact she sees in the people she serves.

“I had a patient, a man, come in one time with numerous chronic medical problems. He wasn’t able to walk, was completely bedridden, depressed, anxious and trying to leave the facility all the time,” she says. “Over time, with therapy and reassurance and medication, he left there walking.”

MARCIA MURPHY *Nurse Practitioner at the Southeast (Atlas) Senior Center*

Marcia Murphy, DNP, ANP, FAHA, FPCNA, is busy. Along with being an associate professor of adult health and gerontological nursing and program director of the adult-gerontology primary care nurse practitioner program at the Rush College of Nursing, every Tuesday morning she drives the 30 miles to a senior center at East 79th Street and South Creiger Avenue, where she is resident nurse practitioner in the center’s wellness program.

The Atlas Senior Center draws older adults, 60 to 100 years of age, from the predominantly African-American neighborhood surrounding it. Many of its seniors use walkers or canes. Many have had strokes or hip or knee replacements. And plenty are in their

70s, 80s and even 90s, exercising and thriving. They’re taking tai chi, Zumba and even belly dancing.

Murphy sees about 25 patients on her visits, and they face a range of health issues. The wellness program also includes seminars on boosting memory or controlling blood sugar, for example. As a nurse practitioner, she collaborates with each senior’s primary care physician.

“The goal is to educate and partner with our seniors so they can maintain their health and independence.” And it’s working. “Almost everyone I see is able to reach their health goals because we have weekly goal setting,” she says.

The frequency of her visits allows both Murphy and her patients to address questions like, “How realistic is this?” “What are the barriers?” “How can this be modified?” The answers help every patient get on a path to success. “Here’s what you gain when you have this situation: A senior might be reluctant to say ‘I haven’t taken medication’ if you see them once a year. I see them weekly. We have a trusting relationship,” she says.

Each Tuesday, it’s not just a time for Murphy to serve the larger Chicago community — it’s a day that consistently challenges her vision of what it’s like to be an older adult.

“It would redefine anyone’s picture,” says Murphy. “It’s the best day of my week.”



“The goal is to educate and partner with our seniors so they can maintain their health and independence.”

REAL NURSING STORIES: LIFE IN THE LABOR AND DELIVERY UNIT

by Amy Lynch



L&D nurses spend their shifts working hard to protect the safety of mothers and infants through a range of responsibilities.

Labor and delivery nurses enjoy the privilege of helping patients through one of the most special and vulnerable experiences of their lives.

Now a registered nurse at Rush University Medical Center, Sharon O'Brien, MSN, RN, CNL, knew she wanted to specialize in this area the first time she stepped into an L&D unit.

"The energy was captivating," she remembers. "The waves of calm followed by surges of chaos and emergency are what made me fall in love with labor and delivery. There are moments of extreme stress and tension, followed by moments of pure joy."

For Rush University College of Nursing GEM program graduate Amy Lang, MSN, RNC-OB, CNL, the idea of working with women and children was a big part of the L&D appeal. GEM is Rush's generalist entry master's program for non-nurses.

"I'm really able to connect with these patients," Lang says. "I haven't had children of my own, but I can relate to them, being a woman who wants to be a mother someday."

L&D nurses spend their shifts working hard to protect the safety of mothers and infants through a range of responsibilities — from monitoring fetal heart rates, managing pain and offering labor support to charting, addressing high-risk situations and providing postpartum care, usually for multiple patients at a time.

Lang works as a registered nurse in L&D at a hospital on Chicago's Southeast Side and says she appreciates the variety her job entails — no two days, patients or situations are ever the same.

"Nursing students spend so much time on med-surgery floors with people who are sick. The fast pace of labor and delivery with a rewarding outcome can be refreshing," she adds.

As with all nursing specialties, L&D involves working as part of a team to provide the best possible patient care. However, the specialty also offers inherent benefits and challenges all its own.

“The waves of calm followed by surges of chaos and emergency are what made me fall in love with labor and delivery.”

"It's a very specialized field that requires nurses to know about other medical/surgical conditions that can affect a patient's labor and delivery experience," O'Brien says. "The labor and delivery unit at Rush functions as an emergency department/triage area, an operating room and a post-anesthesia recovery area."

O'Brien's master's degree included gaining L&D experience at Rush University Medical Center. "In order to complete the program, we had to participate in an immersion rotation in a field we were interested in," she says. "I was able to do my immersion at Rush in labor and delivery. We also had to complete a final capstone project and presentation; mine focused on prenatal care provided at Simpson Academy, a Chicago high school for pregnant students (and young mothers)."

As part of her Rush education, Lang completed 12 weeks of practical orientation with a preceptor (instructor), during which she was assigned patients, which she says helped prepare her for any situation she might encounter on the job.

"You're always dealing with someone in immense amounts of pain who needs support," she says. "As a nurse, you get them through the labor, coach them through delivery and then teach them how to care for their baby. It's a knowledge base you build on forever, not something you can learn from a textbook."

The job of an L&D nurse can be personally and professionally satisfying, but, as Lang points out, also requires a unique kind of compassion in the event things go wrong.

"It's an incredible honor to be part of new life, but it's not all about holding and rocking babies," Lang says. "You also help in times of struggle. This time can be rewarding as well — helping families grieve in times of loss."

"I wish that someone had warned me about the extreme physical nature of this job," O'Brien notes. "I enjoy how physically demanding my work is, but it would have been beneficial to know just how intense the workload can be at times."

Could labor and delivery nursing be the right fit for you? O'Brien suggests reaching out to professors with L&D experience, and if possible, job-shadowing an L&D nurse to see firsthand exactly what the role entails.

"If there's an opportunity for a final clinical or immersion term in labor and delivery, try to arrange one in a hospital or clinic where you'd like to work," she adds.

"Learn as much as you can from clinical (practice experiences), and immerse yourself in that information to understand the basics," Lang says. She recommends that if you can't find an L&D job right out of school, try to work in medical-surgery to improve your time management and pathophysiology knowledge. She also recommends an OB/GYN medical-surgery floor, pediatrics or an ER as a great place to start. 📌





These Nurses Help SAVE THE LIVES of Stroke Patients

by Lisa Jevens

There is a narrow window of time for lifesaving measures, usually only a few hours. Until recent years, stroke victims had little in the way of immediate treatment when they came through the hospital doors. Today, the country has more than 1,000 certified stroke centers where patients are offered the latest in help and hope.

And nurses are at the forefront of this revolutionary stroke care.

Advanced practice nurse Sarah Livesay, DNP, RN, ACNP-BC, ACNS-BC, associate professor at Rush University College of Nursing and a clinician, is one of those nurses. She spends part of her busy days making sure patients get the latest and best care in the neurosciences intensive care unit (neuro ICU) at Rush University Medical Center while instructing other nurses there. She also teaches at the Rush College of Nursing and serves as a reviewer for The Joint Commission, the body that certifies hospitals as specialized stroke centers.

Livesay has been fascinated with stroke care since she saw her first neuro patient 17 years ago as a new nurse. The treatment and care of people who have had brain injuries, seizures and strokes has evolved a lot since then, she says.

“I love the neuroscience field because there is so much happening right now. We are literally discovering new treatments every day,” Livesay says. “What was standard even two years ago has changed. Doctors and nurses are able to be more effective than in the past.”

For example, Livesay recently took care of a young woman who had a stroke while pregnant. “She received tPA (a blood clot-busting drug), and she and her baby were safe,” Livesay reports.



“I love the neuroscience field because there is so much happening right now. We are literally discovering new treatments every day.”

—Sarah Livesay, DNP, RN, ACNP-BC, ACNS-BC
Associate Professor at Rush University College of Nursing

“Then I was on service and admitted an older woman in her 70s whose daughter had called 911 because she thought her mother was having a stroke. The daughter was the woman we had treated before!” Fortunately, the mother also was given tPA in time. “Now she will be able to enjoy her grandchild,” she happily adds.

As a reviewer of hospital stroke programs for The Joint Commission, Livesay and others hope to increase access to the lifesaving treatments certified stroke centers provide. Certification is earned: A center must have up-to-date equipment, offer approved treatments and have staff properly trained for an emergency.

COMPLEX CASES

The world of post-stroke care in the neuro ICU is a minute-to-minute exercise in subtle observation. To properly understand these complex patients, training is crucial. Oftentimes there are multiple medical issues to weigh.

“The acute issue may be the stroke, but they may also have kidney or heart or lung disease or maybe all three. It makes their care much more complex,” Livesay says.

Because strokes occur in blood vessels hidden in the brain or leading to it, the problem is hidden and nurses must interpret subtle changes quickly.

“Even after patients are treated, their condition can change quickly at any moment, and some of the changes are not very obvious,” says Valerie Musolf, BSN, RN, CCRN, CNRN, a clinical nurse educator and a student of Livesay’s in the Doctor of Nursing Practice program at Rush.

“A good neuro ICU nurse will be able to pick up on tiny little things and relate them to what vessels might be affected and what is going on. To work on our unit you have to be very well versed in stroke management,” Musolf says.

PREVENTION & PATIENT EDUCATION

There are different types of strokes with different root causes that require different treatments. For example, bigger blood clots are often manually removed by interventional radiology in a procedure

called a thrombectomy, which is a mechanical way of breaking up the clot using a catheter. Smaller clots may be treated with the intravenous drug tPA.

Stroke patients need a lot of education afterward, because once someone has a stroke there is greater risk of another. But the good news is that most strokes are preventable.

The No. 1 risk factor is high blood pressure. Other risk factors include diabetes, smoking, drinking, atherosclerosis (artery disease) and atrial fibrillation (irregular heartbeat), according to the National Stroke Association. So diagnosing and controlling those conditions is the best thing you can do to lower your risk of stroke.

“Part of being a stroke center is we have to educate every patient before they are discharged,” Musolf says. This is likely what saved the life of Livesay’s patient’s mother, because her daughter was able to recognize the symptoms.

“(The stroke) was unfortunate for the family but it was huge that they recognized the signs,” Livesay says. 🧠



Neuro ICU nurse Valerie Musolf conferring about patient care.

NURSING ON THE FOREFRONT: THE ETHICS OF LIFE AND DEATH

by Laura Lambert



SOPHIA GUARDIOLA, DNP, AGACNP-BC,
found herself constantly wrestling with the issue of quality
of life and wondering why palliative care was underutilized.

Late-stage cancer, Alzheimer's, Parkinson's: When caring for patients with high-risk illnesses like these with unclear roads to recovery, nurses and other medical professionals sometimes grapple with ethical dilemmas as they weigh treatment protocol versus outcomes.

Sophia Guardiola, DNP, AGACNP-BC, dealt with such patients regularly in her 10 years as a registered nurse in one of Rush University Medical Center's surgical intensive care units (SICU).

She recalls that certain critically ill patients would undergo a procedure called extracorporeal membrane oxygenation (ECMO) — a life-sustaining intervention of last resort used only when a patient's heart and lungs can't sustain life on their own. ECMO requires multiple nurses round-the-clock, and the treatment can be administered for weeks — sometimes with very little in the way of progress for the patient, explains Guardiola.

"Seeing patients who aren't waking up, even with such extraordinary measures to sustain their life..." Guardiola explains, her voice trailing off before underscoring her concern. "When they aren't making the meaningful recovery, it's challenging."

THE ALTERNATIVE: PALLIATIVE CARE

As an advocate for her patients, Guardiola found herself constantly



**"Ethical dilemmas
arise from a conflict in
values — and that can
happen all the time."**

—Mary Johnson, professor and assistant dean

🐦 @MaryJohnsonRU

wrestling with the issue of quality of life and wondering why palliative care was underutilized. Palliative care focuses on helping serious ill patients decide on treatment options best for them — with an emphasis on quality of life and reducing suffering.

And as an aspiring doctoral student in Rush's DNP program, Guardiola wanted to do something to explore and then educate others on the merits of palliative care.

"I had to take a step back to understand the problem," she says.

That problem was at the heart of her doctoral project, "Exploring Providers' Perceptions and Attitudes Towards Palliative Care in the Surgical Intensive Care Unit: A Quality Improvement Project." Through a series of surveys and focus groups, she uncovered a stigma — and a disconnect — among various parts of a SICU team around the use of palliative care.

BEYOND 'END-OF-LIFE CARE'

"It's interesting," says Guardiola. "Palliative care is not just end-of-life care — it can be part of curative treatment or pain management." But as she discovered, in the eyes of many health care professionals, palliative care is synonymous with end-of-life — which is at odds with the cure-oriented culture on many surgical teams.

"There was the sense of engaging palliative care as giving up — and no one wants to give up on a patient," says Mary Johnson, PhD, RN, PMHCNS-BC, FAAN, professor and assistant dean for specialty education at the Rush School of Nursing, who worked with Guardiola on her DNP research.

"Ethical dilemmas arise from a conflict in values — and that can happen all the time," explains Johnson. "In the day-to-day practice, different members of the team might approach an issue or a patient situation from a different perspective and there aren't always the mechanisms to resolve the conflict of values."

While all parties on the SICU wanted the same outcome — a positive one — the nurses and surgeons did not always see eye-to-eye about the definition of positive. Was it a cure? Was it quality of life?

And as with all ethical dilemmas, there's not one clear answer. But there can be a way forward.

OPENING A DOOR

Part of the quiet success of Guardiola's project, then, was to open the door for a mechanism to resolve the conflict in values, enabling a dialogue about palliative care that wasn't happening between surgeons and nurses and other hospital staff at the time.

Guardiola's findings lent credence to a growing movement to rebrand palliative care as "supportive care" or "goals of care" — terms both more comprehensive and less associated with end-of-life.

Although Guardiola left Rush Medical Center after receiving her DNP earlier this year to work as an adult-gerontology acute care nurse practitioner in Arizona, she has heard that the culture in the SICU has continued to evolve — and that "supportive care" is increasingly being utilized on her old unit to great effect.

Changing culture anywhere, let alone in a hospital environment, is exceedingly difficult; but it is being achieved through better communication. 🗨️

WHAT YOU CAN DO TODAY TO PREVENT OSTEOPOROSIS

by Amy Lynch

Each year, millions of people 65 and older fall. When they do, bones weakened by osteoporosis are more likely to break or fracture, which can be dangerous and even deadly. And osteoporosis sneaks up on its victims over time.

Here’s what you can do now to safeguard the strength and health of your bones.

According to the National Osteoporosis Foundation, about 54 million Americans are afflicted with osteoporosis or low bone mass. By simplest definition, osteoporosis is a disease in which reduced mineral content in the body can weaken bones, making them more susceptible to breaking. Most people don’t even know they have the condition.

“Because we can’t see our bones, osteoporosis is generally silent until we have a fracture or are screened for it,” says Amber S. Kujath, PhD, RN, ONC, an assistant professor at Rush University College of Nursing. “It’s extremely important to be screened by getting a bone density scan if you have risk factors for the disease or have experienced a fracture.”

Some of those risk factors can include low body weight, prior fractures, a family history of fractures and the use of certain medications. Women are more likely to develop osteoporosis

than men because of decreased estrogen production after menopause.

“Due to higher testosterone levels, males have larger bone size than women based on the same age and body mass index,” notes Sanford Baim, MD, of Rush University Medical Center’s Metabolic Bone Disease Clinic and past president of the International Society for Clinical Densitometry. “Postmenopausal women lose bone at an accelerated rate of approximately 1 to 2 percent per year for approximately three to seven years. After that, women and men lose bone at the same age-related rate of 0.5 to 1 percent per year.”

Bone mass builds throughout childhood and adolescence, peaking between the ages of 20 and 30 before beginning its steady and inevitable decline. Fortunately, there are ways to maintain bone health, even later in life.

“The best way is to follow a well-balanced diet that includes calcium and vitamin D,” Kujath explains. “Vitamin D is needed to absorb the calcium we take in, but it’s rarely found naturally in food. Some foods are fortified with vitamin D — milk, orange juice and cereals; calcium can be found in milk, cheese and some leafy green vegetables.”



“Because we can’t see our bones, osteoporosis is generally silent until we have a fracture or are screened for it.”

–Amber S. Kujath
@OrthoPhDRN

Alcohol consumption can play a role in decreasing bone mass.

“Limit alcohol to no more than 2 ounces, or two moderate-sized glasses of wine, per day,” Baim suggests. “Smoking, too, is detrimental to bone development and repair at any time of the life cycle.”

Maintaining a healthy weight and getting regular exercise can

also help bones stay strong. Kujath suggests activities that “load” our bones, like walking, wearing a weighted vest during walks or resistance training such as lifting weights. She also notes that it’s important to use caution if you’ve already been diagnosed with osteoporosis. Since most of us don’t know our bone density, it’s always a good idea to check in with

your health care provider before embarking on any new fitness regimen.

There are no warning signs of osteoporosis until a fracture occurs, often at the wrist, spine or hip.

“People don’t feel bad if they have osteoporosis, until they fracture a bone,” Baim says. “This is a major problem that results in

not fully appreciating the extent of the disease and complying with medical treatment.”

If a fracture does happen, Kujath advises patients to request additional screening.

“Osteoporosis is most commonly diagnosed by a dual-energy X-ray absorptiometry (DEXA) scan that determines the mineral

content or density of the bones,” she explains.

Using your health information, health care providers can use the web-based fracture risk assessment tool (FRAX) to determine the likelihood of bone fracture occurring within the next 10 years, and then follow guidelines to recommend appropriate treatment, lifestyle changes and medication.

“In recent years, new drugs have been developed that build new bone,” Kujath says. “Before, we only had drugs that would slow bone loss. The new bone-building drugs are very exciting for people with severe osteoporosis.”

To learn more, visit the National Osteoporosis Foundation at nof.org.

How nurses are fighting THE OBESITY EPIDEMIC in pregnant women

by Lisa Jevens

With more than one-third of Americans now considered obese, it seems like everyone from first lady Michelle Obama on down is looking for a way to reverse this deadly trend in our culture.

Unfortunately, obesity — which is defined by a body mass index above 30 — is the new normal in America. (BMI is a measurement of body fat using weight in relation to height.) One in five deaths in America can now be traced to obesity, according to the Centers for Disease Control and Prevention.

Obesity during pregnancy is even more dangerous because it carries severe risks for both mother and baby.

“There are two types of weight concerns with pregnancy: prepregnancy obesity and excessive weight gain during pregnancy,” says Andrea Domas, MS, RD, CDE, LDN, advanced-level dietitian and instructor in the Department of Clinical Nutrition at Rush University.

An obese non-diabetic woman can develop gestational diabetes during pregnancy. That can lead to large babies and cesarean sections; a greater risk of both mother and baby developing Type 2 diabetes later in life. Obesity increases a woman’s risk for high blood pressure, pre-eclampsia, preterm birth and miscarriage. Babies born to obese mothers often have their own health complications, too, according to the National Institutes of Health.

When Megan Polson, a recent graduate of Rush’s Doctor of Nursing Practice (DNP) program, worked at Rush Gynecological Care Group (GCG), she saw all of these problems daily with her patients. She quickly realized that the clinic had a majority population of obese patients who already had the odds stacked against them even before they became pregnant. They lacked affordable nutritional education resources.

“What Medicaid offers these moms is nothing,” Polson says. “They can’t afford to spend \$80 to meet with a dietitian and pay out of pocket.”

Polson was also seeing complications with obese moms who had already delivered.

“I’m pretty passionate about having healthy, happy babies. I wanted to do something about it,” Polson says.

DNP STUDENT PROJECT

For her DNP project, Polson worked with an attending physician at the GCG clinic and reached out to the Department of Clinical Nutrition at Rush. Her project outlined a free program using resources Rush already had: students studying nutrition who needed real-world counseling experience, and their instructor, Domas, who was willing to supervise students working in the clinic one day a week.

Polson and Domas agree the nutritional counseling program made available last year is an all-around success: Patients receive

free care, students obtain great experience counseling a diverse patient population, and the nurses in the clinic have another set of eyes and ears on their patients’ progress.

Domas says good nutrition counseling is individualized and targeted. It starts with setting weight gain goals for pregnancy, helping patients identify potential areas for diet adjustments through, for example, reading labels and journaling or using an app, and educating about other tools to assist with lifestyle changes.

Substituting water for juices and sugary sodas is one example of a small dietary change that can make a big difference, Domas says. Or debunking the myth that only expensive fresh produce is good for you, when, in fact, healthy canned or frozen options are acceptable.

INTERVENTION LIVES ON

Domas admits it can be a struggle for busy moms who lack resources or transportation to make it to appointments and keep track of what they are eating.

But when they do, it’s worthwhile because they’re taking the first step toward breaking the obesity cycle for themselves and their family.

“Our intent is not to overhaul their diet but to guide our moms with simple yet significant changes,” Domas says. “Once they feel up to it after the baby is born, they can follow up with us for more lifestyle changes.”

Polson graduated in August 2016, and has moved on to another city and a new job. However, her brainchild continues to improve the lives of more and more women in the GCG clinic.

“We started out with three patients and now the students are kept busy,” Polson says. Recently, the clinic opened to those who are thinking about getting pregnant as well.

The nurses are teaching those prospective moms what they can do to prevent these problems in the first place, she adds proudly. 📌





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