The Official Publication of the Alabama State Nurses Association

Circulation to 76,000 Registered Nurses, Licensed Practical Nurses and Student Nurses in Alabama
Alabama State Nurses Association • 360 North Hull Street • Montgomery, AL 36104

Volume 38 • Issue 3 **September, October, November 2011**

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Alabama Board of Nursing

Are You on Facebook, Twitter, or Other Social Media Sites? Improper Use Could Result in Licensure Discipline

N. Genell Lee, MSN, RN, JD
Executive Officer, Alabama Board of Nursing

The advent of Social Media (Facebook, MySpace, Twitter, Flickr, blogs, etc) created new ways for individuals to communicate with each other as well as voice opinions for the world to read. Millions of people around the world use the various Social Media tools to invite family members to a reunion, communicate about anti-government protests (as seen in Iran last year), post photos of vacation destinations, and, on some occasions, post inappropriate information.

The Board of Nursing investigates written complaints to determine if a violation of the **Nurse Practice Act** and Alabama Board of Nursing Administrative Code occurred. In the past two years, approximately 10 cases of inappropriate use of social media resulted in discipline of nurses' licenses. Unprofessional conduct was the violation in each of the cases that resulted in discipline. The **Nurse Practice Act** specifies unprofessional conduct as a basis for discipline, "g. Is guilty of unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health." (Ala. Code, 1975, § 34-21-25(b)(1)(g)). The **Alabama Board of Nursing Administrative Code** provides a list of various activities that, if proven, can result in unprofessional conduct discipline. One activity listed is "(h) Failure to respect or safeguard the patient's dignity, right to privacy, and confidential health information unless disclosure is required by law." (**Ala. Admin. Code**, § 610-X-8-.03(7)(h)).

How was social media used to lead to a charge of unprofessional conduct? A licensed nurse posted information on Facebook about her patients. While she did not use names, she indicated where she worked (name of employer) and the unit where she worked. There was sufficient information about the patients that someone could have figured out who the patients were that she was discussing. It also didn't help that she posted the information while at work!

The author has an extensive history in emergency nursing. Those of us who are emergency nurses have seen all sorts of foreign bodies in all sorts of orifices. We also know that patient's often feel humiliated when describing the activity or situation that resulted in a trip to the emergency department. Taking pictures with one's personal cell phone of the foreign body showing on an x-ray and then sending that photo to others is a violation of patient privacy if the patient did not consent. I have slides of foreign bodies from a previous employer that I used for teaching purposes. The difference is that the patients whose pictures I have gave permission for the hospital staff to take a picture for use in teaching. I did not use my own personal camera and I did not take the picture or use the picture without consent of the patient. Facilities have policies about photography of patients and following those policies is especially important when embarrassment may result from a photo being distributed to others. What if the nurse did not take the picture but someone else took the picture? Each licensed nurse still has the responsibility for protecting patient privacy and dignity so if someone else is infringing on the patient's privacy and dignity, the licensed nurse has a responsibility to protect the patient.

The Board also received complaints about postings on Facebook and MySpace with photos of the licensed

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BE SURE TO SAVE THESE DATES

Nurses at the Capitol: February 15, 2012
(Details on web site in early January '12)

Elizabeth A. Morris Clinical Education Sessions–
FACES '12
April 17, 2012

DETAILS AND REGISTRATION FORM WILL BE IN NEXT *ALABAMA NURSE* (and on website *www.alabamanurses.org* mid February 2012

September 20-22, 2012 for the ASNA, AANS, and AlaONE Annual Convention at Embassy Suites Birmingham-Hoover, in Birmingham, AL. Put these dates on your calendar. Full convention materials will be printed in the June/July/August 2012 issue of *The Alabama Nurse*.

It is not too late to register for the ASNA 2011 annual convention to be held at Auburn University Hotel & Dixon Conference Center, October 20-22, 2011. Go to our web site at **www.alabamanurses.org** and register.

Members Only Section ASNA Web Page

www.alabamanurses.org

Look for important issues
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Now On ASNA Web Page www.alabamanurses.org

- **Membership Applications**
- **2011 Convention Registration**

Inside this Issue

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ASNA Board of Directors

ASNA STAFF

VISION STATEMENT
Our Vision

ASNA is the professional voice of all registered nurses in Alabama.

OUR VALUES

- Modeling professional nursing practices to other nurses
- Adhering to the *Code of Ethics for Nurses*
- Becoming more recognizably influential as an association
- Unifying nurses
- Advocating for nurses
- Promoting cultural diversity
- Promoting health parity
- Advancing professional competence
- Promoting the ethical care and the human dignity of every person
- Maintaining integrity in all nursing careers

OUR MISSION

ASNA is committed to promoting excellence in nursing.

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The Alabama Nurse is published quarterly every March, June, September and December for the Alabama State Nurses Association, 360 North Hull Street, Montgomery, AL 36104

Condolences to:

Norma Kappleman in the death of her husband.

Margaret Howard in the death of her daughter. Margaret is past president of District 5.

Dr. Marilyn Rhodes in the death of her sister.

www.alabamanurses.org

Published by:
Arthur L. Davis Publishing Agency, Inc.

PUBLICATION

The Alabama Nurse Publication Schedule for 2011

Issue	Material Due to ASNA Office
Dec/Jan/Feb 2012	November 1, 2011

Guidelines for Article Development
The ASNA welcomes articles for publication. There is no payment for articles published in *The Alabama Nurse*.

1. Articles should be Microsoft Word using a 12 point font.
2. Article length should not exceed five (5) pages 8 x 11
3. All reference should be cited at the end of the article.
4. Articles should be submitted electronically.

Submissions should be sent to:
edasna@alabamanurses.org
or
Editor, *The Alabama Nurse*
Alabama State Nurses Association
360 North Hull Street
Montgomery, AL 36104

The President's Message

Character

by Joyce McCullers Varner, DNP, ANP/GNP-BC, GCNS

In preparing a presentation on ethics a few weeks ago I read an article that inspired this message. The article focused on the six pillars of character and how this is involved in ethical decision making. As nurses today struggle with ethical issues that are new to our profession and society it becomes necessary to take a new look at ethics and its foundation: character. These pillars can act as a filter through which we can process our ethical decisions. They can also help us detect issues where we are focusing so intently on one that we ignore others. We can also use these to improve our character and lives in general.

The pillars of character in the article describe the underpinnings of nursing as a profession. We must possess and employ all of these to be the nurse we are expected to be by society.

The Six Pillars of Character include trustworthiness, respect, responsibility, fairness, caring, and citizenship. The golden rule personified. Covers the most universal virtues. Fits with the struggles of nurses today. This led to me sharing this information with you in this issue.

1–Trustworthiness

When we are trusted by others (and we know that nursing has been the most trusted profession for nearly one hundred years) there is a general consensus that we do not need to be so closely monitored because they know we will meet our obligations. We are held in higher esteem than other professions and that is immensely satisfying to us as nurses. However, we must work diligently to live up to the expectations of others and make sure we are always honest and never self-serving. To just refrain from deception is not enough to earn or maintain this level of trust. There are several components to trustworthiness. *Honesty* is the most fundamental ethical value we possess. Society associate people of honor as leaders and admires, trusts, and depends on them. *Truthfulness* is presenting the facts to the best of our knowledge while couching the facts with mercy if need be. *Sincerity* is being genuine and without duplicity in our dealings with patients and families as well as colleagues and society. *Candor* includes being forthright and frank while again being merciful. *Honesty in conduct* means playing by the rules and doing what we say we will do. *Integrity* means we act according to our beliefs and are consistent in decision making without deviation from our principles whether at work or home. *Reliability* is the act of keeping our promises made. This involves carefully considering if we are willing or likely to keep the promise. As nurses it is easy to want to be involved in everything and the sad fact is that we can only stretch ourselves so thin. *Loyalty* is the responsibility to promote the interests of certain people, organizations, or affiliations and goes beyond the normal obligation we all share to care for others. Loyalty is misguided when another asks us to sacrifice ethical principles in the interest of a relationship.

2–Respect

Everyone has a right to be treated with dignity. This is where the golden rules comes into play. Where we know we should treat others as we would wish to be treated. Respect for others prohibits humiliation, exploitation, violence, and manipulation while reflecting decency, civility, autonomy, tolerance, and acceptance. To treat our patients and others with respect we must allow them to make informed decisions about their own lives, even if we do not agree with their choices. This can be one of the hardest duties of a nurse. We know the consequences of their actions; we educate them, and then must allow them to decide what course they will take.

3–Responsibility

Being responsible means to be in charge of our choices and being accountable for what we do and who we are. We pursue excellence and exercise restraint when necessary. This where we choose to honor or degrade our ethical principles. Responsible people finish what they start and are always looking for ways to make the lives of everyone around them better. Think of the nurse you know who volunteers on his/her time away from work or takes vacation days to respond to a disaster such as the tornado relief work in our state earlier this year. We all know them and maybe we are them.

4–Fairness

Fairness implies adherence to a balanced standard of justice without relevance to one's own feelings or inclinations. Fair people do not wait for the truth to come to them; they seek out the truth and use that truth to make important judgments or decisions. Fairness compels us to employ open and impartial decisions for us and our patients and form these decisions without favoritism or prejudice. We all know that nurse, he/she is the one everyone goes to in order to settle disputes or make the wise decision on important matters.

5–Caring

Caring is the very heart of ethics and it is not possible to be truly ethical and yet not care about the welfare of others. As nurses we realize and acknowledge that it is easier to love humanity than it is to love individuals. However, we know that true caring is the heart of nursing. We must feel an emotional response to the pain and pleasure of others.

6–Citizenship

Citizenship includes civic virtues and duties that prescribe how we should act as part of a community or group. The laws are obeyed and a commitment to public service prevails. This may include giving more than we take.

So, these are the six pillars of character. These are six things that I see when I look at a nurse. These are six things I strive to be. As my grandmother used to say "it costs no more to be nice." She was right. These character traits are also very visible when I sit in a Board meeting with my colleagues and we discuss nursing issues in Alabama. The Alabama State Nurses Association was built on these great attributes. I am inspired and awed by the work this organization does and the commitment to excellence displayed by its members. ASNA advocates for nurses in Alabama and the public who needs our care.

So, if you are a member of this wonderful organization, I salute you for your willingness to serve. If you are not a member, I urge you to join us and help make Alabama a place where nurses are proud to live and work. Remember, we are working for and with you all of the time. Also, let me remind you that there is now a state membership only option.

Also, the annual convention will be in Auburn this year so join us there and enjoy food, friends, fun, education, and a fabulous time!

LPN Corner

"Missed Opportunity"

by Gregory Howard, LPN

Gregory Howard

This is a term frequently used in a Primary care setting, but is not limited to this setting. This term denotes needed information or treatment not done at a recent visit to one's provider. A rule of thumb is to get everything possible done while the client is present. Some of the things that can be missed are: change of address, telephone/cell phone number changes, insurance information, lab test, injections, etc.

So what do you do if something is omitted? Call the client immediately and get the information over the phone or schedule a visit to get only the things you are not able to do by phone. This act satisfies the omission / corrects it in a timely fashion.

This situation can happen in other health care settings such as: Mental Health and Rehab. Medicine, but it takes on a different shape in areas such as these because of the nature of the clinics. But the fact of the omission is the same and the solution would be the same. Call the client on the phone and get the needed information or schedule an immediate visit to get what is needed.

Guess what?" Missed Opportunity "can apply to our personal lives. The way we can combat this to not put off until tomorrow what we can do today. We don't always express our true feeling to the people who mean the most to us. We often ignore the "elephant in the room," for fear of exposure. But who else can we be transparent with, if it's not the people we care for / the person we call friend. Now there is a difference between friend and acquaintance, a huge difference so be careful.

"What we do for ourselves die with us. What we do for others is immortal."

The E.D.'s Notes

The Year in Review

by Joseph F. Decker, II
Executive Director

Joseph Decker

Our annual legislative effort in 2011 met with some success and several disappointments. On the plus side, we were able to retain a total of **$150,000 for nursing scholarships** in the Education Trust Fund Budget despite a very tough financial environment (again) in the legislature. This is significantly less than the $557,000 we garnered in 2007, but still well above the poorly funded $57,000 (or even zero in some instances) of previous years. These scholarships are primarily intended for RNs seeking graduate degrees–both Masters and Doctorate level–who intend to become instructors in our schools of nursing. The Alabama Board of Nursing administers these scholarships to include the application process via their website. These scholarships will allow us to continue our efforts towards working the issue of faculty shortfalls in our nursing schools, and by extension, help attack the overarching problem of the nursing shortage. We owe a great deal of thanks to **Rep. April Weaver, Rep. Greg Wren, House Ways and Means/Education Chair Rep. Jay Love, and Sen. Trip Pittman, Finance and Taxation– Education Chair** for their support and efforts to get this done.

In other legislative news, our ASNA Nursing Scholarship Bill (SB209/HB372) did not pass. This is actually the enabling legislation for the scholarship funds mentioned above. The bill merely updates the language in current law, making constant revisions unnecessary as we go forward. We'll try again next year with what is really a non-controversial change. By the way, we were very pleased with **Rep. April Weaver's** outstanding efforts on our behalf in the House, and **Sen. Tom Whatley's** efforts in the Senate. We fully intend to try again next year, and are guardedly optimistic we'll get it done. The Nurse Practitioners Alliance of Alabama (NPAA) did not field a bill this year to improve the practice environment for nurse practitioners in the state, but we do anticipate a renewed effort in 2012. ASNA will do everything we can to help them in that effort. We strongly believe that overall access to quality healthcare in Alabama, and current underutilization of NPs are the driving issues. The good news is that the subject has previously been broached and will again be on the table. And with the passage of the federal Affordable Care Act the need for additional healthcare providers of all types is manifestly obvious. In Alabama alone we anticipate approximately 500,000 additional patients added to the state Medicaid roles by 2014. This fact alone will add significant weight to the argument for increased use of nurse practitioners. During the annual legislative session you can track issues via our Legislative Updates on our website (www.alabamanurses.org); we posted 4 updates this year at roughly three week intervals. Update #11-4 has a pretty good summary of the entire session for your review.

Our political plans for 2012 are already taking shape, with the Nursing Scholarship bill and the NPAA bill opening up NP practice restrictions on the first page. We will be working with the members of the Alabama Nurses Coalition and partnering with AARP for another push. We have also opened talks with the Alabama League of Women Voters and the Medicaid Commission on that subject.

Our **Alabama Nurse Foundation** awarded three scholarships and a total of $7,500 in 2010, and will award $8,000 in 2011. Fundraising efforts continue, and the ANF Board led by **President John Beard, Ralph Chester and Juanzetta Flowers**, hopes for a better year going forward, especially if the economy improves. To be brutally frank, we must dramatically improve our funding for ANF or the possibility of awarding any scholarships at all next year will be in serious jeopardy. In addition, the Nurses Foundation, under the leadership of President Dr. Joyce Varner, also collected donations of just over $1500.00, distributed to nurses needing assistance around the state following the terrible tornadoes/storms on 27 April. Please consider making a donation to the Alabama Nurse Foundation, sent to ASNA; 360 N. Hull St.; Montgomery, AL 36104. Remember that the ANF is a 501(c)(3), and all contributions are fully tax deductible.

On the business front, I am pleased to report that your association is again on very solid ground. Our annual financial compilation from Wolf & Taunton, PC demonstrates that very clearly; the full report is available to members in the ASNA office. For the ninth year in a row, we will finish the year with a balanced budget, solid cash operating reserves, and no requirement to access any of our Strategic Reserve funds at Merrill Lynch. That Strategic Reserve fund is up 6.15% from its balance one year ago, following a 10% gain the previous year. All things considered, and with the turmoil in the economy we have experienced, we are satisfied with that result.

Our annual ASNA **"Nurses at the Capitol Rally"** held on Wednesday, 6 April from 10:00AM-12:00 noon on the steps of the Alabama State House was another big success. As you may recall, we had originally scheduled the rally for the 9th of March, but a certain forecast of not only rain and thunderstorms but perhaps even severe weather forced us to cancel and reset for 6 April. (By the way, the weather on the 9th of March was, in fact, awful!) That hiccup notwithstanding, we successfully reset and had a great crowd of nearly 500 in attendance. The Brookwood High School Band under the direction of Craig Henson provided outstanding music and entertainment and injected lots of energy into the assembly. (Thanks to Dr. Ruby Morrison for arranging their appearance). **Gov. (Dr.) Robert Bentley** was our lead speaker and, as is his custom, had wonderful things to say about nurses in Alabama. We very much appreciate him taking the time from his busy schedule to be with us. In addition, **Rep. Greg Wren** (R) Montgomery, **Rep. April Weaver** (R) Alabaster and **Sen. Tom Whatley** (R) Auburn addressed the crowd and were enthusiastically greeted. We are grateful to all of them for taking the time to talk with us during a very busy legislative day in Montgomery. Other outstanding speakers in the program included **Dr. Joyce Varner,** ASNA President; **Richard Brown**, NPAA President; **Dr. Diana Dowdy**, CNM; and, subbing for **Dr. Ruby Morrison**, AL Nursing Coalition President who was ill, Dr. Morrison's daughter **Melissa Hatter**, RN and a graduate student studying to become a nurse midwife. The entire event was emceed by our own **Deborah Andrews**, Chief Nursing Executive at Cooper Green Mercy Hospital in Birmingham. We also had enthusiastic participation from student nursing groups from **Auburn Montgomery, Snead State Community College and Northwest Shoals Community College.** Finally, we had excellent press coverage again this year from NBC/WSFA-TV and CBS/WAKA-TV in Montgomery and ABC Channel 32 in Dothan. We are planning next year's event already, and have tentatively set a 15 February 2012 date.

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The Year in Review continued from page 4

ASNA's annual FACES continuing education event held on 26 April at the Eastmont Baptist Church in Montgomery was again a huge success, with attendance just under 700. This year we had 10 tracks from which to choose: Cardiology; Clinical 1, 2 and 3; Psych/Mental Health; Obesity; Diabetes; Pediatrics; AANS/Student (NCLEX, etc.); and a grab bag of "mini" or stand alone miscellaneous topics. The AM plenary session was presented by Deborah Kilgo, RN on Immunization in Alabama (sponsored by Pfizer) and the PM session by Dr. Lynn Hillhouse on The Concept of Resilience in Nursing (sponsored by Arthur Davis Publishing). With over 40 topics and as many different speakers–all outstanding, of course–just about every interest was covered. We also enjoyed poster presentations, with 34 available on a myriad of subjects. And of course we had the usual superb hospitality from the entire staff at Eastmont Baptist. To all that attended: thank you so much. And to those that missed out: check this space and the ASNA website for next year's FACES event (to be held in 17 April at the same location). You won't want to miss it!

We regret to announce that **Dr. Ruby Morrison**, past ASNA President and Chair of the **Alabama Nurses Coalition** has had to withdraw for health reasons, recently retiring from her post as Professor at the University of Alabama Capstone College of Nursing. Thankfully **Deborah Andrews**, CNE at Cooper Green in Birmingham and an outstanding nurse leader in her own right, has stepped in to take her place. The future remains bright for this important effort. On a brighter note, we are very pleased to announce that former long-time ASNA Executive Director **Elizabeth "Liz" Morris** has been named to the Alabama Nursing Hall of Fame, with induction at ceremonies in Tuscaloosa this October.

I would be remiss if I failed to mention your ASNA Staff and all their hard work and loyalty this past year. **Charlene Roberson**, Director of Leadership Training and Continuing Education; **Betty Chambliss**, Office Administrator; and **April Bishop**, Programs Coordinator have all gone above and beyond expectations on a regular basis to provide our association with outstanding service and support. Without their tireless efforts and energetic execution we simply would not get the work done here at the ASNA office. In addition, our ASNA attorney, **Don Eddins**, has provided his usual excellent legal advice and lobbying assistance with the Legislature throughout the year. We owe all of them a very big Thank You and Well Done.

We were pleased to present our fifth **ASNA Face of Nursing Calendar** at our **2011 Annual Convention, 20-22 October in Auburn**. This is an effort to spread the word about ASNA, nurses and nursing/healthcare issues around our state. We hope you enjoy it, and will use it to advertise for our association throughout the year ahead. And finally, we look forward to gathering again for **Convention 2012** at the Embassy Suites in Hoover, 20-22 September. See you there!

Alabama Board of Nursing continued from page 1

nurse off-duty. While you may not "friend" individuals on Facebook that you don't know, your friends have friends who have friends. The Board investigates complaints by reviewing what is on Facebook. Sometimes the postings are borderline acceptable. A photo of a nurse who appears drunk and posts information about how much booze he ingested or the newest drug that he tried raises concerns for many members of the public. The nurse may say that the Board has no authority to review what is done in off time. However, the Board routinely disciplines nurses for behavior or conduct that occurred and ended with the licensed nurse having criminal charges.

Storytelling is common among nurses. Sharing information about difficult patients, the impact of patients on us, and talking about difficult families helps us get through tough days. When we are treated as servants rather than professionals (room service in a hospital is different than room service in a five-star hotel!), we may want to share our frustrations with our colleagues. Debriefing with members of the health care team following a particularly difficult case may be useful to address the concerns and responses of those caring for the patient. Posting the frustration or concerns about the difficult case on social media sites could result in the reader being offended that a member of the nursing profession complains about patient care. A report to the Board of Nursing may follow.

The next time you think about posting a comment about patient care on one of the social media sites that you use, ask yourself if the same comment (or photo) would be appropriately posted on the front page of a newspaper along with your identification as the one who posted the comment. If the answer is "No" it would not be appropriate on the front page, do not post it to a social media site!

Any questions about this topic or other issues, feel free to contact the Board of Nursing or the author (abn@abn.state.al.us; Genell.Lee@abn.alabama.gov).

Legal Corner

by Don Eddins, BS, MS, JD

Did you know that the Alabama Board of Nursing is composed of 13 members, including eight registered nurses, four licensed practical nurses and one non-nurse consumer?

Did you know that the practice of nursing in Alabama is governed by the Nurse Practice Act, which can be found in the Code of Alabama 1975 at Sec. 34-24-1?

Did you know that the Alabama Board of Nursing implements the Nurse Practice Act through the Alabama Administrative Code at Chapter 610?

It is important that all professionals stay abreast of latest laws and regulations affecting their professions. With the huge majority of our nurses being internet savvy, in these modern times there is no reason why practitioners cannot keep up with rules and statues.

Just search Alabama Secretary of State or Alabama Board of Nursing on the Internet. The state's laws and administrative code are at both sites. And for the old fashioned among us, any library should have a copy of the Code of Alabama and the Administrative Code.

Nurses often look at the Nurse Practice Act and the Board of Nursing in a negative way. And as with most licensure agencies, the Board does seem to take the position that the nurse is guilty of poor job performance unless she is able to prove otherwise.

But the purpose of the act and the Board is to protect nursing and the public by promoting quality nursing care–which is something that we all want. In fact, registered nurses are nursing's own harshest critics. After all, if the Board of Nursing has a strict guideline, remember eight of the 13 members of the Board are registered nurses and it they who voted the rule into existence.

Read the Nurse Practice Act and you can update your knowledge on rules relating to practice. You can also learn about proposed rules that could impact your practice in the future. You can learn about specific "Standards of Nursing Practice" (610-x-6) and "Disciplinary Action" (610-x-8) when those standards are breached.

You can learn continuing education requirements (610-x-10) and about the alternative program for practitioners who need assistance with substance abuse issues.

You can learn all about what is expected of you as a registered nurse in the state of Alabama.

Nurses also need to acquaint themselves with local policies of the institutions where they work. There are broad "Dos" and "Don'ts" in the Nurse Practice Act, but many institutions have more detailed policies about work place issues, such as medication administration or abandonment.

Knowledge is the key to success in any profession. It is especially important in such a critical field as nursing, because, as we all know, registered nurses deliver the bulk of the direct care in our hospitals and nursing homes.

Lessons In Leadership

by Karen Daley, ANA President

There is no question that nurses make a difference everyday in the lives of their patients. I believe–and I am not alone–that much more potential exists for the nursing profession to make a difference. New emphasis has been placed on nursing as an untapped resource with the power to transform the quality of health care delivery in this country.

The Affordable Care Act calls for a larger role for nurses in the design of more efficient and cost-effective models of health care delivery. Led by a committee of nationally renowned experts from nursing, medicine, and other disciplines who reviewed the body of scientific evidence, the Institute of Medicine Future of Nursing committee also concluded that nurses must take a greater leadership role in the design and delivery of care.

Here is a summary of key messages that I believe nursing as a profession must act on in order to realize our true potential for transforming health care:

Nurses are the key to quality care in a transformed health care system. Health care, experts and patients alike are calling on our profession to optimize its contributions to better meet the needs of all patients for quality health care. All patients would benefit if nurses were empowered to practice to the full extend of their skills and education.

Nurses' knowledge and expertise are in demand. It's time for each of us to step up and meet the challenge. This is a once in a lifetime opportunity for every nurse to seize the opportunity and "become the change you want to see."

What we do today will influence how our health care system looks in 10 years. The public's high regard for the profession, coupled with nurses' education and skills, make us well positioned to assume a major role in transforming the nation's health care system. If our profession doesn't answer the call, others will. Every nurse has a role to play in transforming nursing and health care delivery.

Your professional association is a key partner on this journey to maximize this opportunity by advocating for leadership roles for nurses in patient-centered care, encouraging your involvement in shaping the future, and providing tools and resources to support your success.

How can we, as nurses, get involved?

- Think about where you want to be in your Practice in five years–set career goals and Identify what you will need to get there.
- Commit yourself to lifelong learning. Pursue Advanced education through CE, certification, and academic education.
- Stay informed and apply for grants, scholarships, and other programs that can enhance your opportunities and support a larger role for nurses.
- Don't let policy happen 'to you'–get involved in the policy committees at work and through your state association.
- Your voice, experience, and expertise is needed to help design and implement improved care environments and models. No one knows what patients want and need better than nurses.
- Participate in workforce planning surveys and data collection opportunities. As nurses, we must measure the value of what we do.
- Stay informed about and participate in the activities of your professional associations. A few hours of your time can make a big difference; remember there is strength in numbers.
- Embrace and act on your power!

New ANA-PAC Board Members Elected

ASNA Members elected Chair and Vice-Chair

SILVER SPRING, MD–The American Nurses Association (ANA) announced the election results for the new members and officers of ANA's Political Action Committee (ANA-PAC) Board of Trustees. The ANA-PAC works to raise funds from ANA members and supports candidates for federal office who have demonstrated their belief in ANA's legislative agenda. ANA-PAC board officers are elected to serve a one-year term. The new board will establish the presidential endorsement task force and has set a goal of raising one million dollars for the 2011-12 election cycle.

Newly elected ANA-PAC Board of Trustees officers are as follows:

Lori Lioce, DNP, FNP-BC, NP-C; chair

Lioce is a nurse practitioner at Huntsville Hospital Emergency Department and a clinical assistant professor at University of Alabama-Huntsville, College of Nursing. A member of the Alabama State Nurses Association, Lioce completed a four-year term on the ANA Congress on Nursing Practice and Economics (CNPE) in 2010 and serves as the immediate past president for the Nurse Practitioner Alliance of Alabama. Lioce has served as vice-chair of the ANA-PAC Board of Trustees since 2008.

Linda Easterly, MSA, BSN, RN; vice chair

Easterly is the chief nursing officer of Parkway Medical Center in Decatur, AL. A member of the Alabama State Nurses Association, Easterly served in the U.S. Air Force for more than seven years and her previous positions include chief nurse at Barrow Regional Medical Center in Winder, GA; director of the Occupational Health & Wellness program for Houston Healthcare in Kathleen, GA; past president of the Georgia Nurses Association; and past member of the Georgia Board of Nursing.

Congratulations to Lori and Linda.

CE Corner

Call for Abstracts/ Proposals

Elizabeth Morris Clinical Education Sessions–
FACES '12
Montgomery, Alabama
Tuesday, 17 April 2012
Oral and Poster Presentations

Proposals/abstracts will be reviewed for a 1 hour oral presentation or Poster Presentation.
Oral presentations should:

- Be clinical focused
- Have relevance to the clinical setting(s)

Poster presentations may be any of the following:

- Research focused
- Innovations in teaching
- Projects

Proposal Guidelines

- Abstract for Posters
- Oral presentation - Content outline including 1- 3 measurable objectives and teaching methods
- Must not exceed 250 words
- Do not include presenter names in the abstract or content outline

Method of Submission is online at
www.alabamanurses.org
Deadline: 10 January 2012

The Best Care for Elders at End of Life

Saturday, 12 November 2011
Loeb Conference Center ~ Old Alabama Town
301 Columbus St ~ Montgomery, Al 36104

Cost: $55 ASNA members
$69 non members

Contact Hours: 6.0 (ANCC) 7.2 (ABN)

8 am Registration

8:30 am
Caregiver Journey (stages and tasks of the care giving experience)
Cultural Aspects for both patient and caregiver
Necessary conversations and adaptation techniques when communication barriers are present
Age appropriate pain management
Support during frailty
Gentle art of balancing management of multi-morbidities

4: 00 pm *Evaluation*

Goal: Improve the quality of care at the end of life for elders

Objectives:

1. Explore the unique physical and emotional needs of elders as compared to younger counterparts at their end of life.
2. Relate to others the usual stages and tasks caregivers experience when dealing with end of life experiences.
3. Describe communication adaptation techniques for elders when they have communication barriers at the end of life.
4. Summarize the cultural impact at the end of life.
5. Discuss providing appropriate end of life care when physical problems are overwhelming issues for both the patient and caregiver.

Faculty:

Arlene Morris, EdD, MSN

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Helen Wilson, MSN, RN

All Faculty are certified End of Life Educators

Accreditation:
The Alabama State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Alabama Board of Nursing Provider Number ABNP0002 *(valid until March 30, 2013).*

Refunds: If cancellation is received in writing prior to Nov. 4, 2011 a refund (minus a $20.00 processing fee) will be given. After Nov. 4, 2011 no refund will be given. We reserve the right to cancel the program if necessary. A full refund will be made in this event. A $30 return check fee will be charged for all returned checks/payments.

Registration Methods:
Mail:
ASNA
360 N. Hull St.
Montgomery, AL 36104
Fax: 334-262-8578
Online: alabamanurses.org

The Best Care for Elders at End of Life

Name: _____ Credentials: _____

Address: _____

Day Phone: (_____) _____ Email: _____

Payment Method: _____ ASNA Member $55 _____ Non Member $69 **After November 4, 2011 add $15**

Credit Card #: _____ _____Check–Make Payable to ASNA

Signature _____ Expiration Date: _____ Security Code:_____

Confirmations by Email Only ~ Licenses Will Be Scanned at the Workshop
Mail registration form to: ASNA, 360 N. Hull St., Montgomery, AL 36104 OR Fax to 334-262-8578 / Register online at www.alabamanurses.org. Confirmation by Email Only

Alabama Board Of Nursing
Board of Nursing Established Call Center

After three years of planning, the Board of Nursing recently opened a Call Center. The volume of phone calls, live chats, and emails consistently increased each year. For the month of July, 2011 (excluding state holidays and weekends), the volume for the 20 days of the month when the Board office was open was: phone calls (to main numbers) 4,157; Live chats via the internet 460 for a total of 4,360 minutes; and emails to the main email address were 255.

The Call Center is staffed by three full-time operators and three back-up operators. Providing quicker access for those contacting the Board is an attempt to improve customer service. The phones are answered by live persons and there is no automated menu. We also added additional lines for incoming facsimiles as we received complaints that incoming facsimiles exceeded the capacity of our fax line. The Call Center staff answers the initial calls to the Board's main numbers as well as answer live chats and emails. Any issue that the Call Center cannot handle will be forwarded to the staff for that particular area.

The establishment of the Call Center resulted in new telephones and changes in telephone numbers. The main contact information is 1-800-656-5318, 334-293-5200, fax: 334-293-5201; email: abn@abn.state.al.us. Live chat is accessible from the front page of the Board's web site, www.abn.alabama.gov.

CE Corner

Insomnia

Authored by: Charlene M. Roberson, MEd, RN-BC, Director of Leadership Services, Alabama State Nurses Association.

Intended Audience: RN and LPN

Disclosures:
1. The author discloses no conflict of interests.
2. The activity is valid through 14 August 2013.
3. Course requirements–see directions

Goal: The purpose is to review usual causes and treatment modalities for insomnia.

Objectives: At the completion of this course the participant should be able to:
1. List at least four (4) risk factors for insomnia.
2. Discuss evaluation techniques used for insomnia.
3. Contrast the various treatments for insomnia.
4. Describe the nursing role in the treatment of insomnia.

Directions: Read the monograph *Insomnia*. Complete the Post Test and evaluation and return both completed forms to ASNA (360 N. Hull Street, Montgomery, Alabama 36104 or (F) 334-262-8578). A Continuing Nursing Education certificate of completion will be sent to you upon successful completion of the post-test and evaluation sheet. You must score at least 80% on the post-test to pass. Should you score below 80%, you will be notified and offered the opportunity to retake the post-test for an additional cost of $5.00.

Board of Nursing Transcript: ASNA will enter the course on your Alabama Board of Nursing transcript **(you will be unable to successfully enter the course on your transcript)** within two weeks of successful completion of the activity.

Contact hours & Accreditation:

This 2.0 contact hour course (60 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association. The Alabama State Nurses Association is an accredited provider of continuing nursing education by the American Nurses Credentialing Center Commission on Accreditation (ANCC).

This 2.4 contact hour course (50 minutes equal 1.0 contact hour) activity is provided by the Alabama State Nurses Association, which is approved by the Alabama Board of Nursing, provider number ABNP002 (valid through 30 March 2013).

Fees:

ASNA Member: $15 Non-member: $24

Shipping and Handling: $4.00 (only if mailed to you)

Insomnia

There are numerous different sleep disorders and this article will focus only on the most common both in the United States and worldwide–insomnia. The Diagnostic Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Sleep Disorders (ICSD) are both benchmarks for sleep classification. In each, insomnia is described as difficulty falling asleep *(sleep onset insomnia)*, staying asleep *(sleep maintenance insomnia)*, and non-restorative *(or poor quality)* sleep for at least one month. In addition to these preceding subjective complaints, a person must also experience daytime dysfunction due to the loss of sleep. Most everyone has an occasional night of poor or interrupted sleep and this is not classified as insomnia. Insomnia may be primary when it occurs in isolation of other causes or in conjunction (comorbid) with other medical or psychiatric disorders. Due to its self reported nature, there is no way to be sure of exact numbers. However, the incidence reported in the literature of chronic or long-term (more than a month) insomnia varies from 1/3 to 1/2 of the population.

The American Academy of Sleep Medicine reports that insomnia causes a substantial economic burden. A good example is found in a 2009 Canadian study. Selected examples cited include:

- 76% of all insomnia costs are related to lost hours of work productivity amounting to 27.6 lost days of total productivity for individuals with chronic insomnia and 6.2 days/year for individuals with insomnia symptoms
- Absences from work directly related to insomnia account for 4.36 days /year
- Highest direct cost to treat insomnia is the use of alcohol as a sleeping aid (alcohol is a poor sleeping aid as it makes you sleepy initially and interrupts sleep about 4 hours later)
- Health care visits to a physician/nurse practitioner account for about 3% of total costs

In the past insomnia was believed to be transient in nature and occurred secondary to medications, medical problems, psychiatric disorders, or other sleep disorders. The treatment decisions were based on the belief that once the comorbid problem(s) were resolved the insomnia would also resolve. Now, based on scientific evidence accumulated during the last 20 years, the treatment focus has changed. Today insomnia is recognized as a separate independent disorder which may also be present with a comorbid condition. Now insomnia is actively treated as its presence may exacerbate, precipitate, or prolong a comorbid condition.

Risk Factors–There are many identified risk factors for insomnia. The general belief is that probably the exact mechanism is not fully understood. There are a number of theories and several selected ones follow:

Hormonal–Individuals who have insomnia often have excess weight problems. Some of the theories center on hormonal imbalances as it is recognized that lack of sleep alters these balances. For example, the body produces serotonin and dopamine during sleep. When the sleep cycle is too short the body produces less serotonin and dopamine and seems to compensate once the person is awake by increasing a desire for sugary foods. Once the sugary foods are ingested an immediate increase of these hormones occurs. Another hormonal imbalance is the relationship between ghrelin and leptin. Ghrelin is the first hormone identified with obesity. The secretion of ghrelin makes you feel hungry even when your body has had sufficient food. After eating the body secretes leptin which gives the full satisfied feeling. Sleep deprived individuals have a decreased release of leptin. The end result of an imbalance of these two is a craving for sugary foods and over eating.

Gender–Women have the highest rates of insomnia in every age group and despite many theories no one seems to have an accepted scientific based explanation. The most widely accepted belief/theory is that women in their younger childbearing years are constantly vigilant to the possible awakening of a child and thus do not sleep as soundly as men. As a woman ages and enters the perimenopause and menopause phase of life normal hormonal changes occur. Associated with these changes are the vasomotor symptoms (sweating and hot flashes) both of which lower sleep efficiency and are associated with increased nocturnal arousals. Also during this phase of life the incidence of depression and anxiety increase in women. There is a positive correlation between anxiety and depression and insomnia in all age groups. Another factor linked to insomnia is an interrupted marital status which could be separation, divorce, or widowhood. The fact that women live longer has been purported to be a cause of increased reported rates of sleep dissatisfaction.

Age–Epidemiological studies have provided evidence that the elderly are much more dissatisfied with their sleep quality as compared to younger individuals. There are normal age-related changes in the architecture of sleep and these changes seem to make the elderly more vulnerable to sleep disruption. To be specific, as we age the total time in deep or REM (rapid eye movement) sleep decreases and at the same time the total time in lighter sleep or Stage 1 and Stage 2 increases. The average time a healthy elderly person sleeps is approximately 7 hours/night. As a rule disturbed sleep is rare in healthy older adults. They may awaken more often but manage to easily return to sleep and feel refreshed upon awakening. Many elderly do have insomnia and it is usually related to a co-occurring medical condition. Their sleep disruption may be related to the medical conditions or the medication(s) used to treat the condition(s). When elderly have an initial onset of insomnia it is often linked to heart disease, hip fracture, stroke, or an onset of depression. The elderly need a careful assessment as to the cause. Insomnia can be more severe as compared to younger adults because the adverse effects of insomnia (e.g. concentration and memory impairments as well as slowed reaction time) can be mistaken for dementia which can lead to an incorrect diagnosis. Overall insomnia is associated with more accidents (at all ages not just the elderly), greater risk for falls, and a poorer quality of life. Elderly living outside their homes in assisted living or long term care facilities have many more issues interfering with adequate sleep–especially greater exposure to light, noise, and other environmental factors. Retirement, although a developmental milestone, has some negative aspects related to insomnia. Insomnia increases when a fixed schedule is no longer maintained. Some retirees may feel a lack of purpose and usefulness in life leading to boredom. Others in retirement have physical problems forcing them into an increased sedentary life style. *(Even the young have problems with insomnia when spending prolonged time in a chair or a bed.)* Not only do these individuals not become tired but they also nap during the day; all of which seem to disrupt sleep.

Shift Work–According to the National Sleep Foundation a shift worker is anyone not working 9–5. Evening shift workers sleep the most sleep followed by the day shift workers and the least sleep is noted on the night shift. Night shift workers report difficulty in falling asleep and remaining asleep. All workers sleep more on off days. Although the main complaint of most shift workers is excessive sleepiness the incidence of insomnia is fairly high. *Tips to control or prevent insomnia are located in fig. 1*

Insomnia Prevention Tips for Night Shift

- Consume caffeine early in shift not later
- Drink plenty of water
- "Graze" on lower fat and lower sugar snacks during the shift
- If rotating shifts change shifts in a clockwise schedule
- Keep the lights on and the temperature to 68–70 degrees in the workplace
- Wear dark glasses to block out the sunlight on your way home
- Keep same wake and sleep times even on off days
- Eliminate noise and light from bedroom–eye masks and ear plugs
- Avoid alcohol before bed time

Fig 1

Psychiatric Illness–By far the most common co-morbidities of insomnia are depression followed by anxiety and other mood disorders. Frequently, insomnia is a precursor to depression and depression is exacerbated by insomnia–thus a never ending circle. Individuals with insomnia have a lower rate of adherence to the treatment regime and overall have a decreased response to therapy. Persons with depression often remark that insomnia is the first symptom noted and the last symptom to resolve. Clinically, the depression resolves more quickly when the insomnia improves. Relapse occurs more quickly in patients whose insomnia does not resolve. Insomnia is associated with an increased risk of suicide with at-risk suicide patients.

NOTE: Insomnia has a high correlation with both Post Traumatic Stress Disorder and anxiety (probably because the individual has a reduced capacity to cope with stress). It is also a predictor of a manic episode(s) in bipolar patients.

Chronic Pain–A correlation between chronic pain and insomnia has long been known and many replicated scientific studies have provided evidence. Selected examples include a relationship of arthritis and restless sleep; another is an increase in pain intensity and a decrease in emotional well being as a result of poor sleep. Pain often makes sleep difficulties worse and poor sleep usually makes the perception of pain worse. Studies of individuals with Fibromyalgia relate less pain when satisfied with their sleep. The incidence of poor sleep also intensifies with complaint of muscular aches, tenderness and fatigue.

Obesity–Obesity is most often correlated with obstructive sleep apnea. Whatever the cause obese individuals usually have poor sleep. And inadequate sleep is a risk factor for obesity.

Diagnosis/Evaluation of Insomnia–The diagnosis of insomnia starts with an assessment of a detailed sleep history as well as psychiatric and medical histories. Types of questions included in a sleep history include the following:

- usual bed time
- usual awake time
- total time in bed
- frequency of awakening
- length of sleep before awakening (if multiple awakening how long is sleep between)
- napping history
- stimulant use (any medications, tobacco, etc.)
- alcohol and caffeine (how much and at what time ingested)
- exercise (how much and how close to bedtime)
- sleep environment (ambient noise, bed partner snores or is restless, animals/children in bed, temperature of room, etc.)
- relaxation measures before bedtime, e. g. reading
- any other data the patient may have such as a sleep log (date, bed time, how long it takes you to fall to sleep,

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number of times awake & for how long, last awake time/get up, naps & how long, how you feel in morning)

In addition to the sleep history the following will also be evaluated:

- type of insomnia
- duration
- precipitating factors especially psychosocial issues
- any/all comorbid conditions–medical, psychiatric, and/or substance use/abuse

Typical data collection methods include symptom checklists, bed partner interviews, at least a two week sleep log, and psychological screening tests (if indicated).

There are a number of sleep evaluation measures and not all are appropriate for diagnosing insomnia. The ones seldom used are polysomnography (useful for diagnosing sleep apnea, movement disorders, or precipitous arousals occurring with injurious or violent behavior) and multiple day time sleep latency tests. In addition routine screening laboratory test are not indicated.

Treatment Approaches–The treatment plan/goal is to improve the quality and quantity of sleep as well as reduce or eliminate day time impairments. In addition to the medical treatment of any comorbid condition the person with insomnia needs specific treatment for the sleep disorder. There are three different treatment options. The first is behavioral therapies which include cognitive therapy, cognitive behavioral therapy, relaxation techniques, and sleep restriction therapy. The second treatment modality is medications, which include benzodiazepines, melatonin agonists, and nonbenzodiazepines. The third is a combination of the preceding two options. The decision as to the most effective treatment is based on the severity of the insomnia, coupled with the availability of clinicians who are trained in the specific behavioral therapies needed for sleep management, and the client's motivation and desires. There is no consistent scientific data supporting an advantage of Options 1, 2, or 3. No matter what option(s) are chosen the initial treatment will be sleep hygiene; it is not optional. Sleep hygiene encompasses the actions clients' take to improve and/or maintain adequate refreshing sleep. Not all of the components of the "text book plan" are effective and doable for everyone. The first action is for the individual to evaluate their current sleep practices and then determine where changes need to be made. It is essential to tailor an individual plan for each person. The plan must be realistic or the person will not it continue on a daily basis. The most common components are as follows <u>and pay special attention to items preceded by a star as they are not optional</u>. *NOTE: These actions are only for individuals with insomnia; ignore them if you do not have a sleep problem.*

- ***Sleep as long as desired to feel rested (usually 7-9 hours for adults) and then get out of bed
- ***Keep a regular schedule even on off days (and even if you work the night shift)
- Do not take naps
- Limit caffeinated beverages after supper and if very sensitive to caffeine limit after lunch (trial and error will be necessary to determine best time to limit caffeine). Will need to become aware of hidden sources of caffeine, e.g. sodas, chocolate, etc.
- ***Avoid (at least limit) smoking after supper. Never get up in middle of your sleep cycle to smoke as cigarettes are a stimulant
- Never go to bed hungry
- Warm milk (and cookies) does help some to sleep, but not everyone–again trial and error to determine if milk provides sedation
- Avoid forcing sleep
- Adjust the temperature of the room, most sleep better in slightly cooler environments
- ***Limit stimuli in bedroom; determine what keeps you awake or what awakens you, e.g., TV, barking dogs (use ear plugs), a bed partner who snores, animals (cats and dogs, etc.) in your bed, food crumbs in the bed, uncomfortable mattress, etc.
- ***Regularly exercise enough to become tired (minimum of 20 minutes/day) and for most individuals no later than 3-5 hours before bed time as exercise is stimulating.
- Bedroom is for sleep or for being close to your partner, not eating, watching TV, balancing the checkbook, planning the grocery list, etc.
- ***Control and/or resolve worrying and concerns before bedtime (may need professional help to resolve issues)

Cognitive Behavioral Therapy (CBT) always starts with an evaluation of the preceding sleep hygiene measures. In fact sleep hygiene forms the basis of the CBT treatment plan. The goal is to alter behaviors which are not conductive to sleep. These recommendations are augmented with basic behavioral techniques such as stimulus control therapy, sleep restriction therapy, etc. This is a training course lasting 8–10 weeks. Specific cognitive therapies are often coupled with a plan which includes correcting maladaptive thoughts. The effectiveness of CBT has been well documented, but with limitations. The limitations are that it is time consuming, requires a change in the patient's behavior (often the biggest hurdle of all), and a skilled practitioner is needed to facilitate the patient's change in behavior. Behavioral therapies include the following:

<u>Relaxation</u>–a systematic method to progressively relax muscles from head to toe (or reverse). There are various methods to facilitate this. It may be a physical act to consciously relax muscle groups or relaxation by listening to music.

<u>Stimulus Control</u>–This is based on the fact that some individuals associate the bedroom with staying awake and not for sleep. The process is to remain in bed no more than 20 minutes, if you do not go to sleep get up go to another room and do something relaxing such as reading or watching TV, return to bed when feeling sleepy. If not asleep in 20 minutes get up and repeat the process until it is time to get up. Remember to set the alarm and get up at the usual time. Do not nap during the day. Often individuals do not sleep the first couple of nights but finally will sleep due to exhaustion and lack of naps during the day.

<u>Sleep Restriction</u>–This technique is aimed at individuals who remain in bed later in the morning because they did not sleep well at night. The result is a need to remain in bed longer the following morning and the following morning and the following morning… The process if to initially estimate the number of hours per night that you sleep. You then decrease the total time allowed in bed to the average sleep time or a total of 4 hours (whichever is greater). You must have a rigid bedtime and awakening time. Naps are not permitted. The result is sleep deprivation which means you will sleep better the next night. Time in bed is gradually increased based on total sleep time. The longer you sleep the more time is allowed in bed for sleep, i. e., Day 5 you sleep 5 ½ hours so Day 6 you are allowed 5 ½ hours in bed.

<u>Cognitive Therapy</u>–This is working on a 1:1 basis with a therapist to deal with anxiety and negative thinking.

The behavioral therapies are time consuming and may not be reimbursed by insurance carriers thus medications are often the first treatment modality. Insomnia has been treated with medications since the 1800s. The most common of the oldest sedatives were chloral hydrate, paraldehyde, and bromide. In the early 1900s these drugs were replaced by barbiturates–notably amobarbital (Amytal), pentobarbital (Nembutal), secobarbital (Seconal), and phenobarbital (Luminal). And these were widely used until the 1960s. There were side effects of both of these preceding groups of medications. The most common were drowsiness, lethargy, and a morning hang over. Alcohol potentiates these medications and alcohol is the most common over the counter agent used for sleep. Barbiturates have a great risk of tolerance development, addiction, and death by overdose. Today these medications are no longer considered appropriate treatment for insomnia.

The next class of drugs used for insomnia was the benzodiazepines (BZDs). Over the years BZDs have proved to be much safer especially in regard to overdose as compared to the barbiturates. This drug classification mediates gamma amino butyric acid (GABA) sites and does not distinguish among the 5-6 various GABA sites. In short not all BZDs mediate the same GABA site(s). BZDs in general have sedative, anticonvulsants, muscle relaxant, anxiolytic (antianxiety), and hypnotic effects. Some of the more common specific medications with predominant sedative properties which are used to treat insomnia include flurazepam (Dalmane), quazepam (Doral), temazepam (Restoril). These drugs with the predominant sedative properties have very little impact on the anticonvulsant, muscle relaxation, and anxiolytic sites.

Today Best Practice Guidelines provide parameters for clinicians when selecting specific drugs for the treatment of insomnia. This decision is based on a number of factors as follows (and these are in no particular order):

- presenting symptoms or type of insomnia
- overall treatment goals
- availability of other treatments
- past treatment responses
- cost
- client preference
- comorbid conditions
- current medications and potential interactions
- side effects (especially those that might interfere with a job)
- contraindications

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BZDs in general have a quick onset of action due to the rapid absorption across the blood-brain barrier. Clinically the half life BZDs is very important. This characteristic has enabled practitioners to match dosages based on clinical needs. A short half life is useful for individuals who have trouble falling asleep where as a long half life is useful for maintaining sleep. Some specific side effects include hyperexcitability (especially in the elderly who need lower dosages due to decreased rate of metabolism and elimination), agitation, anxiety, next day hang-over which also includes confusion and amnesia, and somnambulism. Many patients develop physiologic symptoms (dependence and increased tolerance) with long term use. An abrupt cessation may lead to rebound insomnia. On a short term basis these drugs have proven to be safe and the potential for abuse remains low. However, many individuals with insomnia use them on a long term basis and develop problems–most notably cognitive and psychomotor impairments, dependence, and tolerance. Although their use to promote sleep has declined in recent years you will see clients still using these drugs for sleep. They are being replaced by sedating antidepressants, i.e., trazodone (Deseryl) and the newer hypnotics. BZDs remain in favor for treatment of anxiety and seizure disorders and in some cases of insomnia (especially when there is an overriding anxiety component). The newest hypnotics are the benzodiazepine receptor agonist (BzRAs). BZDs and BzRAs have the same basic mechanism of action. The BzRAs have some/selected pharmacodynamic properties that seem to improve safety and tolerance. Prior to 1995 the FDA guidelines specified "short term use" for sleep medications. This is no longer in effect as all currently FDA approved sleep medications have had ample trials and have demonstrated continued efficiency without development of tolerance. In addition the medications have proved to be safe. BZDs and BzRAs are controlled Substance Schedule IV. Of note is the impact of smoking on BZDs. According to the FDA, hepatic clearance is accelerated in smokers as compared to non smokers resulting in a reduced drug half life. The mechanism, although not clearly understood is thought to be the result of enzyme induction. In short, smokers have shorter drug half life.

Ramelteon [Rozerem] was approved by the FDA in 2005. It is the "new kid on the block" for sleep medications. This was the first new sleep medication with a different mechanism of action approved in 35 years. Its action is that of an agonist so it binds selectively with melatonin receptor sites. By stimulating these sites the circadian rhythm is impacted and this in turn impacts the sleep/wake cycle.

Today the FDA has approved 10 different drugs for insomnia. They are the 9 BzRAs hypnotic formulations and the one selective melatonin receptor agonist.

Medications Approved by FDA for Insomnia

Generic Name	Trade Name	Onset	Half Life
BzRAs			
estazolam	ProSom		10-24 hrs.
flurazepam	Dalmane	15-45 mins.	47-100 hrs.
quezepam	Doral	rapid	47-100 hrs.
temazepam	Restoril	30-45 mins.	10-20 hrs.
triazolam	Halcion	30-45 mins.	2-3 hrs.
eszopiclone	Lunesta	rapid	5-7 hours
zaleplon	Sonata	rapid	1 hr.
zolpidem	Ambien	1 ½ hrs.	2-3 hrs.
zolpidem ext. rel.	Ambien-CR	rapid	
Melatonin Agonist			
Ramelteon	Rozerem	rapid	2-5 hrs.

The general medication treatment sequence for primary insomnia is as follows:

- Initial short acting BZD, BzRA (eszopiclone [Lunesta], temazepam [Restoril], zaleplon [Sonata], zolpidem [Ambien], or ramelteon [Rozerem]).
- If this is unsuccessful the next treatment is to alternate a short or intermediate acting BzRA with ramelteon [Rozerem].
- If a person has a comorbid depression or anxiety the drugs of choice are sedating antidepressants, i.e., amitriptyline [Elavil], doxepin [Sinequan], mirtazapine [Remeron], trazodone [Deseryl].
- If the preceding treatment is unsuccessful with a person with depression or anxiety the clinician may combine sedative antidepressant with either BzRA or ramelteon [Rozerrem].
- Depending on co morbid conditions some clients with insomnia respond well to the sedating effects of both anti-epilepsy medications, i. e., gabapentin [Neurontin] or tiagabine [Gabitril] or atypical antipsychotics, i.e., Olanzapine [Zyprexa] or quetiapine [seroquel]. Often clients are already on the medications so it becomes an issue of changing the dosage times and amounts during the day.

Individuals often use over the counter agents to induce sleep. The most common is alcohol which had an initial sedative property followed by arousal about 4 hours later. Probably safer for sleep induction is the use of diphenhydramine [Benadryl]. The major problem is that long term use decreases sleep efficiency. Other herbal sleep aids often used are melatonin and valerian. These are not recommended by the FDA because lack of efficacy and safety research data; however, these drugs have been researched in depth by European studies and found to be safe.

Nursing management–The nursing role is that of support and provision of education about the treatment plan as well as the medications themselves. Components of this plan should include

- Goals and expectations of the treatment plan including the expected treatment course and discontinuation of drugs
- Need for tapering and discontinuation of medications when indicated.
- Support and clarification of CBT if used
- Side effects–both expected and unexpected of medications and potential interactions with other medications, supplements, and alcohol
- Safety concerns including potential dosage escalation
- Rebound insomnia
- Need for regular follow up evaluations during the initial treatment phase to assess for complications, effectiveness and a need for continuing the medications

Clients with severe or refractory insomnia and/or a chronic comorbid condition sometimes do not respond to the short term use of hypnotics thus they will have some special management needs. At a minimum they need to understand why. The treatment will probably extend to include long term use of medications. It may be nightly or intermittent (e.g., 3 nights week) or as needed. If resources are available for CBT, it should be combined with the long term use of the sleep medication(s). Whether CBT is used or not the client needs consistent follow up including assessment of side effects and an evaluation of the occurrence of either a new onset or exacerbation of existing comorbid conditions. Taking a pill to cure sleep problems is easier than CBT. And there is no clear cut scientific evidence to support CBT alone, medication(s) alone, or a combination of the two. The challenge for nursing is to assist the client to understand rationale for the treatment plan and the need for continued follow up assessments.

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Insomnia Post Test

Select the one best answer.

1. Sleep maintenance insomnia is best described as remaining asleep.
   A. True
   B. False

2. Individuals with insomnia frequently are overweight.
   A. True
   B. False

3. The production of serotonin and dopamine is increased when insomnia is present.
   A. True
   B. False

4. The greatest incidence of anxiety, depression, and insomnia in women tend to be in the perimenopausal years.
   A. True
   B. False

5. The majority of the healthy older adults have some form of disturbed sleep.
   A. True
   B. False

6. Evening shift workers have the lowest incidence of insomnia.
   A. True
   B. False

7. The most common co-morbidities of insomnia are depression and anxiety.
   A. True
   B. False

8. Insomnia is rarely a predictor of mania in bipolar patients.
   A. True
   B. False

9. Polysomnography is a useful tool for diagnosing insomnia.
   A. True
   B. False

10. Sleep hygiene will be the first tool any practitioner uses to treat insomnia.
    A. True
    B. False

11. Scientific data supports the most effective treatment of insomnia is to incorporate sleep hygiene and relaxation therapy.
    A. True
    B. False

12. Most individuals sleep better in a cooler environment.
    A. True
    B. False

13. Individuals with insomnia should make every effort to remain in bed and try to sleep for at least 6 hours before getting up.
    A. True
    B. False

14. The goal of cognitive behavioral therapy is to alter behaviors which are not conductive to sleep.
    A. True
    B. False

15. During sleep restriction therapy naps are permitted if you become exhausted.
    A. True
    B. False

16. Early sleep medications often were associated with a morning hangover or lethargy.
    A. True
    B. False

17. Benzodiazepines with predominant sedative properties also have a predominate muscle relaxation properties.
    A. True
    B. False

18. All current FDA approved medications for insomnia basically work in the same manner.
    A. True
    B. False

19. Medications chosen for insomnia vary based on the patient's clinical profile.
    A. True
    B. False

20. Sedating antidepressants are an effective treatment for insomnia.
    A. True
    B. False

21. BzRAs have little impact of tolerance development.
    A. True
    B. False

22. FDA guidelines no longer recommend only short term for sleep medications.
    A. True
    B. False

23. Tobacco users need a lower dose of benzodiazepines because of the increased half life of the drug.
    A. True
    B. False

24. Long term use of diphenhydramine (Benadryl) as a sleep aid is discouraged because it decreases sleep efficiency.
    A. True
    B. False

25. The role of nursing is the treatment of insomnia is that of support and provision of education about the treatment plan.
    A. True
    B. False

Evaluation/Post Test ~ Insomnia

2.0 (ANCC) 2.4 (ABN) contact hours Activity #: 4-0.927

Goal: Review usual causes and treatment modalities for insomnia.

Name, Credentials: _____ ___ Member ($15)

Address: _____ ___ Non Member ($24)

_____ ABN License#: _____

City State Zip

Phone: _____

Email: _____

_____/_____ _____ _____

Credit Card Number **Exp. Date** **CVV#** **Signature**

Place answers to post test in designated box below number, and return only this page.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
19	20	21	22	23	24	25											

Activity Evaluation ~ Circle your response using this scale: **3 –** ***Yes*** **2 –** ***Somewhat*** **1 -** ***No***

Goal & Objectives were appropriate.				3	2 1
Rate your achievement of the objectives for the activity					
List at least four (4) risk factors for insomnia.				3	2 1
Discuss evaluation techniques used for insomnia.				3	2 1
Contrast the various treatments for insomnia.				3	2 1
Describe the nursing role in the treatment of insomnia.				3	2 1
Program free of commercial bias.				3	2 1
Content can be applied to my Nursing Practice &/or Life Style.				3	2 1
On a scale of 1–5 / 1 (low) 5 (high) knowledge of topic before home-study	5	4	3	2	1
On a scale of 1–5 / 1 (low) 5 (high) knowledge of topic after home-study	5	4	3	2	1

How much time did it take you to complete the program? _____ hours _____ minutes.

ADDITIONAL COMMENTS:

Membership News

New/Renew/Rejoin Members:

REMEMBER:
70% of your dues are tax deductible!

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Research Corner

Adolescents with Higher Socioeconomic Status at Greater Risk for Substance Abuse During Early Adulthood

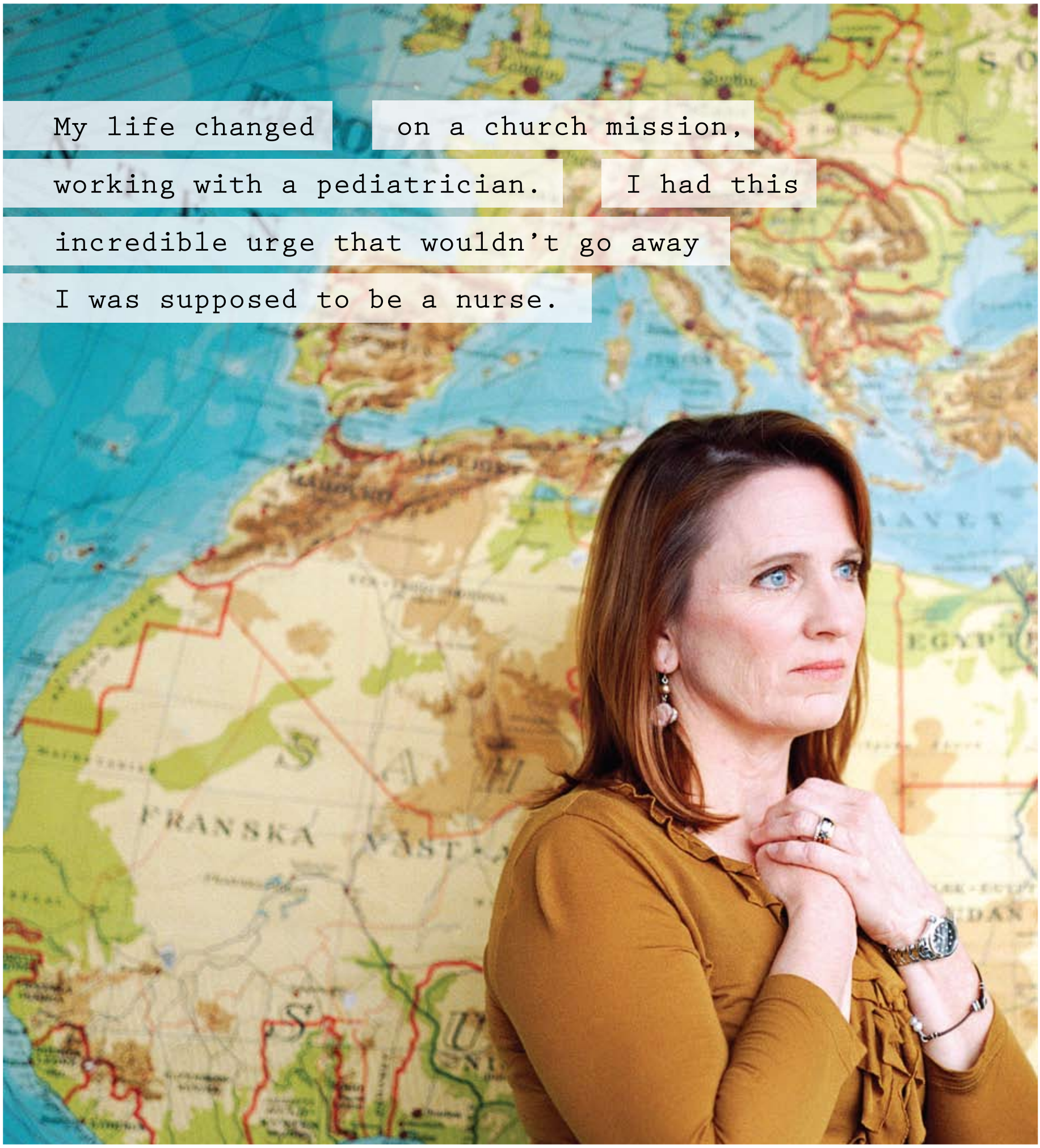
Previous research has shown that adolescents with low socioeconomic status (SES) are more likely to engage in substance abuse, as are adults with high SES. Yet a new study reveals that adolescents with high SES (measured by parental education and household income) are also at risk for substance abuse. It found that higher SES among adolescents was associated with greater rates of binge drinking and marijuana and cocaine use in early adulthood. There was no significant correlation between high SES in adolescence and crystal methamphetamine or other drug use.

Study author, Jennifer Humensky, Ph.D., of the University of Chicago, analyzed data on 9,872 adolescents taken from the National Longitudinal Survey of Adolescent Health (AddHealth). AddHealth tracks students in grades 7-12 and their parents, and includes a follow-up interview when respondents are 18-27 years old. Results showed that higher parental education was associated with higher odds of binge drinking and marijuana use and cocaine use in early adulthood. Higher household income in adolescence was associated with a higher probability of binge drinking and marijuana use.

When stratified by race, results were consistent for whites but no significant results were found for non-whites. This may be related to the smaller sample size of the non-white sample, but it could be that the results are driven primarily by white respondents, notes the author. The results of the study are consistent with previous research in adults, which found that demand for illicit substances is price-sensitive, and thus predicts that substance abuse will increase as income is higher. This study was supported by the Agency for Healthcare Research and Quality (T32 HS00084).

See "Are adolescents with high socioeconomic status more likely to engage in alcohol and illicit drug use in early adulthood?" by Dr. Humensky in *Substance Abuse, Treatment, Prevention, and Policy 5* (19), pp.1-10, 2010. MWS

SUSIE MARTIN | RN | CARDIAC CARE UNIT



Some of us knew when we were young. Some felt called later in life.

Somewhere along the line it became our dream. In an epiphany, or dawning realization, we knew absolutely we wanted to be a nurse. UAB nurses will tell you that there's a unique and intangible quality in being at UAB. Perhaps it's the camaraderie, or the acuity of the patients, or the way the physicians respect you. It's hard to pin such a life-changing experience to a single reason. It's simply different. And it represents the fulfillment of many, many dreams. **It is also why when you're a UAB nurse, you're not just another nurse.**

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