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 “(b) 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) (b)).

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 nurse’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. Those of us who are emergency nurses have seen all sorts of foreign bodies in all sorts of orifices.
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

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• 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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Character

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 live 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 we need to be so closely monitored because they know we will keep our promises made. This involves carefully considering if we are willing or likely to keep the promises we make. 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 come 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. The golden rule comes into play here. 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 decisions 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 nurses 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!
The E.D.'s Notes

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 $50,000 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 used by RNs, 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 a visit to get only the things you are not able to garner in 2007, but still well above the poorly funded $57,000 (or even zero in some instances) of previous years. These scholarships are primarily used by RNs, 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 a visit to get only the things you are not able to.

What is the Year in Review?

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 $50,000 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 used by RNs, 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 a visit to get only the things you are not able to.
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 records and examining reports. 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 from 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 appropriate 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 (april@alab.net).

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 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 an abuser or abuser.

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 is their job to vote 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 about all that 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.
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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 extent 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 and 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, 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 nurses 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

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 Parkview 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 Kathlen, GA; past president of the Georgia Nurses Association; and past member of the Georgia Board of Nursing.

Congratulations to Lori and Linda.

University of South Alabama
College of Nursing

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The University of South Alabama is now offering an online BSN-DNP Adult-Geron NP track with a Palliative Care specialty. Graduates will be prepared to provide and manage evidence-based primary and palliative health care for individuals in primary care clinics, assisted living facilities, nursing homes, hospice and palliative care facilities, and other ambulatory care settings. Graduates will also coordinate and develop health care programs for adults and those living with or dying from chronic, progressive illnesses. There is also a Post Masters and Post Doctoral option available for those interested in only Palliative Care. Graduates will be eligible to seek certification as Adult Nurse Practitioners (ANPs) in primary care and certification in advanced nursing practice in hospice and palliative care through the National Board for Certification of Hospice and Palliative Care Nurses (HCPCN).

For more information call Dr. Joyce Varner, Program Director: 251-445-9455 or email jvarner@usouth.edu

Visit our website: http://www.southalabama.edu/nursing/geron.html

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Auburn University Montgomery is an Equal Opportunity/Equal Access institution and committed to achieving excellence through diversity; therefore, we encourage applications from historically under-represented groups.

American Nurses Association

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.

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:

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Call for Abstracts/Proposals

Elizabeth Morris Clinical Education Sessions–FACES
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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 clinically focused
- Have relevance to the clinical setting(s)
Poster presentations may be any of the following:
- Research focused
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- 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
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- Fax: 334-262-8578
- Online: alabamanurses.org

The Best Care for Elders at End of Life
Saturday, 12 November 2011
Low 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 multimorbidities

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.

The Best Care for Elders at End of Life

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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 (main number) 4,157; Live chats via the internet 460 for a total of 4,660 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 faxes as we received complaints that incoming faxes 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: 334-293-5200; email: abn@abn.state.al.us. Live chat is accessible from the front page of the Board’s web site, www.abn.alabama.gov.
Insomnia continued on page 10
Insomnia continued from page 9

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
- medications being used
- 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 daytime 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 continue on a daily basis. The most common components are as follows and pay special attention to items preceded by a star as they are not optional:

- ***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)***
- Limit caffeinated beverages after supper and if very sensitive to caffeine limit after lunch (trial and error)

Sleep Restriction—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 the 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.

Cognitive Therapy—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, antianxiety (anxiolytic), 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 and treating insomnia. This decision is based on a number of factors as follows (these are in no particular order):

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

Insomnia continued on page 12

September, October, November 2011
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Our earliest students came to TROY to learn how to help others. Today, our degree programs continue to attract those looking for careers shaping a life of service... such as nursing.

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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 hypersexuality 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 cognition, 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 (Deserly), 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 results 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.

Ramechon [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 melanin 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 hypnogenic formulations and the one selective melatonin receptor agonist.

**Medications Approved by FDA for Insomnia**

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Onset</th>
<th>Half Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estazolam</td>
<td>ProSom</td>
<td>10-24 hrs.</td>
<td></td>
</tr>
<tr>
<td>Flurazepam</td>
<td>Dalmale</td>
<td>15-45 mins.</td>
<td>47-100 hrs.</td>
</tr>
<tr>
<td>Zolpidem</td>
<td>Ambien</td>
<td>1½ hrs.</td>
<td>5-7 hours</td>
</tr>
<tr>
<td>Zaleplon</td>
<td>Sonata</td>
<td>1 hr.</td>
<td>1-2 hrs.</td>
</tr>
<tr>
<td>Zopiclone</td>
<td>Ambien-CR</td>
<td>Rapid</td>
<td>2-5 hrs.</td>
</tr>
</tbody>
</table>

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

- **Initial short acting BZD.** BzRAs (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 [Deserly].
- If the preceding treatment is unsuccessful with a person with depression or anxiety the clinician may combine sedating antidepressant with either BzRA or ramelteon [Rozerem].
- Depending on comorbid 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 a change of 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 the drugs have been researched in depth by European studies and found to be safe.

**Selected Bibliography**

- Zammitt, Gary K. The prevalence, morbitities, and treatment of insomnia. CNS & Neurological Disorders. 6 (2007), 3-16.
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)

City  State  Zip  Phone: __________________

ABN License#: ___________

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.

Rate your achievement of the objectives for the activity

List at least four (4) risk factors for insomnia.

Discuss evaluation techniques used for insomnia.

Contrast the various treatments for insomnia.

Describe the nursing role in the treatment of insomnia.

Program free of commercial bias.

Content can be applied to my Nursing Practice &/or Life Style.

On a scale of 1–5 / 1 (low) 5 (high) knowledge of topic before home-study

On a scale of 1–5 / 1 (low) 5 (high) knowledge of topic after home-study

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

ADDITIONAL COMMENTS:
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 heroin 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 HS00904).

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
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2. You provide care outside of work.
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3. You won’t be forced to compromise your professional reputation to minimize claim costs.
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